Recovery, Spirituality and Religiousness in Schizophrenia

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Abstract

Recovery is an important element in the care of patients with severe mental disorders such as schizophrenia. Being a process rather than a goal, recovery involves taking into account patients' preferences in terms of values and life goals. Data showing that religion and spirituality can be an important part of recovery have begun to appear in the literature. Indeed, religious coping appears to be important for patients with schizophrenia, not only as a way of coping with their disorder and other life issues, but also in terms of one's identity and setting important life goals. By contrast, the deleterious influence of religion on positive symptoms may have been overestimated, as there is no evidence supporting this hypothesis. Even if a minority of patients experiences delusions with religious content, this does not appear to constitute, a fortiori, a negative issue, as qualitative research shows that this does not hinder patients from gaining some help from religion or spirituality. Psychiatrists should consider religion when treating patients with schizophrenia, first with a spiritual assessment. This leads to various issues such as mobilization (from a social and day-to-day living perspective), working on one's identity, understanding spiritual crisis and others. Also, illness and treatment representations may be influenced by religion in various cultural backgrounds, which should be discussed with patients in order to improve adherence and, thus, foster recovery-oriented care.

Key Words: Recovery, Schizophrenia, Religion, Spirituality

Introduction

Recent research (1, 2) has noted how psychosocial factors may affect the risk and the clinical outcome of psychoses such as schizophrenia. In the field of psychopharmacology, the enthusiasm for the new second-generation antipsychotics has been tempered by recent research (3, 4). In this context, it is necessary to reemphasize psychosocial treatments, which remain the cornerstone of the treatment of patients with severe mental disorders.

Schizophrenia and other psychoses affect the whole life of patients. Consequently, treatments should comprehensively cover all affected fields. This should include individual approaches directed at support (e.g., supportive therapy) and cognitive approaches (5), and might also involve a psychodynamic perspective (6) (even if it may be difficult to associate both behavioral interventions and more psychoanalytically-oriented approaches due to specific therapeutic modalities [7]). Comprehensiveness also involves a variety of actions, including assertive community treatment, family and individual psychoeducation, supported employment, social skill training, and integrated treatment for substance misuse (8).

These elements need to be integrated into a general framework in order to avoid fragmentation of care, which

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constitutes a piecemeal network whose complexity poses a barrier to patient access. For this purpose, the concept of recovery supplies a holistic perspective on the care of patients with severe mental disorders (e.g., schizophrenia). Psychological recovery denotes the development of a fulfilling life and a positive sense of identity founded on hopefulness and self-determination (9). It has recently been recognized as an organizing principle for the systems of care for the mentally ill that can replace paternalistic, illness-oriented services (10).

From this perspective, it appears that religion/spirituality can be an important component of recovery, as has been suggested by research (11). Indeed, often being an essential coping mechanism, religion/spirituality may help to deal not only with illness (e.g., symptoms) but also to help with social and day-to-day living difficulties.

In this review, we will describe how religion/spirituality can be considered in the care of patients with schizophrenia from the perspective of recovery. After going into further details concerning the concept of recovery, we will describe what research has shown concerning the relationship between religion and psychosis. Finally, clinical intervention considerations and/or integrating religious components will be detailed.

Recovery as an Organizing Principle

Due to various causes (among which treatments themselves may play a role), the identity of patients with schizophrenia may become organized around the role of psychiatric patients, thus leading them to being passive recipients of care (12). Orienting care around recovery may overcome this important problem, as recovery involves: 1) finding hope, 2) reestablishing one's identity, 3) finding meaning in life, and 4) taking responsibility (9). Recovery has recently gained stature, in part because of the consumer movement, but also as a consequence of the development of psychiatric rehabilitation (10). In the United States, recovery has been boosted by the release of the President's New Freedom Commission Report in 2003, which indicated the need to move toward consumer and family-driven services (13). Briefly stated, recovery involves "recovery in" serious mental illness as opposed to "recovery from" serious mental illness (14). This involves the concept that persons with severe mental disorders may be (and should look forward to) living fulfilling lives, despite the persistence of residual symptoms. Guidelines have been developed to facilitate the transformation of services according to this concept of recovery (10). Beyond organization and training issues, treatment features should include a variety of services that support consumer self-sufficiency, encourage the utilization of advance directives, provide culturally sensitive treatments, emphasize consumer choice, integrate treatment of co-occurring substance abuse, limit the use of coercive measures, address barriers to access, and provide family services and a full array of training opportunities. It is within this framework that we can study, assess and intervene on issues such as spirituality and religion when treating people with psychosis.

The Interface between Religion, Spirituality and Psychoses such as Schizophrenia

This description makes it possible to infer what role religion may play in recovery-oriented care: first, religion is indisputably part of one's identity, i.e., an important element of recovery; second, religion can offer opportunities for patients in terms of goal setting such as occupational activities; but, overall, it can constitute a way to fulfill one's aspirations in terms of important life goals combining both social and self-accomplishing dimensions. Further, recovery, in cultivating the positive elements of a person's life, may lead to issues other than religion, e.g., the field of positive psychology, which involves the search for play, pleasure and joy (15).

The interface between psychosis and religion has been shaded by historical misunderstandings. Although Freud himself never directly attributed psychosis to religion, he understood religious beliefs as rooted in fantasy and illusion (16). Freud may have been right in this observation, while indirectly acknowledging the fact that religion may help to cope with day-to-day living difficulties. Recent research has studied with a more neutral attitude how persons with psychosis deal with religious issues. First, we report on this by considering religion as a coping mechanism and then by looking at religion as a phenomenological dimension of patient's symptomatology.

Religious Coping in Patients with Schizophrenia or Related Psychoses

According to consumers' opinion, religion and spirituality can be a major resource in recovery (17). To our knowledge, there are only a few outcome studies examining the role religion may play in the prognosis of psychoses such as schizophrenia (both in terms of symptom relief or recovery). Not much is known as to how religiousness by itself evolves with time in patients with psychosis. A recent study (18) gives some indication that religious coping may influence the outcomes of patients with serious mental illnesses. Indeed, religious coping variables accounted for variation in adults' reports of psychiatric symptoms and personal loss one year later over and above demographic and global religious variables. While waiting for more data, we may rely on cross-sectional studies, which yield conclusions quite pertinent for clinical practice. These studies generally give indications that religion may be a useful domain of investment for patients, thus leading to improved recovery.

Studies have been conducted on spiritual/religious coping in various populations. Tepper et al. (19) showed that eighty percent of patients with persistent mental illness used religious beliefs or activities to cope with daily difficulties or frustrations, particularly those who were experiencing more severe symptoms. Pargament (20) suggested that religious coping potentially serves several purposes: spiritual (meaning, purpose, hope), self development, resolve (self-efficacy), sharing (closeness, connectedness to a community), and restraint (help in keeping emotion and behavior under control). Religious coping may be adaptive or not. Pargament and colleagues (21) identified four approaches to religious coping with adversity: the collaborative style (a joint responsibility for problem solving by God and the individual), the deferring style (placing all responsibility on God), the self-directing style (emphasizing one's personal responsibility) and the pleading style (the petition for God's miraculous intervention through the use of pleading and bargaining). On various populations, the last coping style has been shown to be maladaptive (22). One may infer that collaborative and self-directing coping styles may be part of the recovery process of patients suffering from severe mental disorders such as schizophrenia, as it involves, at least to some extent, taking responsibility. Yangarber-Hicks (11) showed that among 151 patients with serious mental illness (among whom about fifty percent suffered from schizophrenia or schizo-affective disorders) the collaborative coping style was associated with greater involvement in recovery-enhancing activities and empowerment, while the deferring strategy was associated with improved quality of life. This latter result, which may be counterintuitive, together with the fact that the self-directing coping style was not linked with positive psychosocial functioning, led the author to suggest that self-sufficiency does not promote life satisfaction in this population. This may be due to the fact that patients unhappy with their circumstances may have abandoned their religious commitment. Another explanation could be that collaborative and deferring strategies could be a way to give up control in a situation that, in some ways, is out of the person's control. The fourth coping style (the reliance on pleading) was associated with increased level of symptomatology.

Further studies gave more information on spiritual and religious coping through qualitative approaches. Bussema and Bussema (23) found that patients with severe mental disorders (not only psychotic conditions) used all of the coping functions described above. However, the "restrain" factor (the way to keep them from undesirable actions) was the least effective way to manage their symptoms. These authors pointed out that nonadaptive religious coping, at times, hindered efforts to manage negative symptoms such as feelings of guilt and hopelessness, and of being ignored, judged or condemned by the religious community. Moreover, in the absence of fellowship, both faith and hope were difficult to sustain over the persistence of the illness.

Indeed, often being an essential coping mechanism, religion/spirituality may help to deal not only with illness (e.g., symptoms) but also to help with social and day-to-day living difficulties.

In a quantitative and qualitative research (24), we studied the role of religion/spirituality as a coping mechanism among patients with psychotic disorders. These were 115 patients between 18 and 65 years of age meeting the *International Classification of Diseases, Tenth Revision (ICD-10)* (25) criteria for a diagnosis of schizophrenia or other nonaffective psychoses and treatment followed in our four Geneva, Switzerland psychiatric outpatient facilities. We developed a semistructured interview inspired by several scales or questionnaires, including the "multidimensional measurement of religiousness/spirituality for use in health research" (26), the "Duke Religion Index" (27) and a questionnaire on spiritual and religious adjustment to life events (20). Our interview instrument explored the spiritual and religious history of patients, their beliefs, their private and communal religious activities, the importance of religion in their daily lives, the importance of religion as a means of coping with their illness and its consequences, the synergy versus incompatibility of religion with somatic and psychiatric care, and their ease in speaking about religion. For almost half the patients (45%), religion was the most important element in their lives. Religion was used as a positive way of coping in 71% of subjects and as a negative way of coping in 14% of patients. Recently, these findings were replicated with 126 patients living in Quebec, Canada (28). The subjective importance of religion, the religious practices and the rate of positive/negative coping were remarkably similar to those from our Geneva cohort.

As for the elements of positive and negative religious coping, the following provides more details concerning our Geneva patients.

Positive Coping

At a psychological level, religion gave these patients a positive sense of self (in terms of hope, comfort, meaning of life, enjoyment of life, love, compassion, self-respect, self-confidence, etc.). For two-thirds of these patients, religion provided meaning to their illness, mainly through positive religious connotations (a grace, a gift, God's test in order to grow in spiritual life, a spiritual acceptance of suffering,

etc.) and less frequently with negative connotations (devil, demons, God's punishment, etc.). However, even if those meanings were negative in religious terms, they were positive in psychological terms by fostering an acceptance of the illness or a mobilization of religious resources to cope with the symptoms, as indicated by the content analysis. For three-quarters of the patients, religious coping had a positive impact on symptoms (e.g., by lessening the emotional or behavioral reactions to delusions and hallucinations and/or by reducing aggressive behavior).

At the social level, religion provided guidelines for interpersonal behavior, which led to reduced aggression and improved social relationships. Unfortunately, in spite of the subjective importance of religion, only one-third of the patients using religious coping in a positive way actually received social support from a religious community. Some patients did not receive any support from their communities due to their symptoms. More often, symptoms hindered religious patients from practicing in their religious communities.

Negative Effects of Religious Coping

Fourteen percent of patients reported the negative effects of religious coping. For those patients, religion was a source of despair and suffering. Some patients felt despair after failure of the spiritual healing they had sought. Others used religion to cope, but with a negative outcome. Although religion was meaningful for these patients, it always carried negative religious connotations. In some cases, religious coping increased delusions, depression, suicide risk and substance intake. Only one patient found community support, but this led to a loss of faith and an increase in his medication compliance.

Overall, it appears that religion can serve as a powerful coping mechanism among patients with psychosis, as for other "healthy" people. The main difference is that patients may have difficulties in developing social contacts in this area, which has important therapeutical implications (see below).

The Role of Religion on Other Aspects (substance use, suicide risk …)

Religious coping may also play positive and negative roles in the frequent comorbidity associated with schizophrenia.

Suicidal Behaviors

Religion may protect against suicide attempts. This is known for various populations (29). In the previously mentioned Geneva research, we saw that twenty-five percent of all subjects acknowledged a protective role of religion against suicide, mostly through ethical condemnation of suicide and through religious coping (30). However, one out of ten patients reported a suicidal incentive role of religion, not only due to negatively connotated issues, but also in the hope for something better after death. The positive role of religion included not only religious coping and ethical condemnation of suicide, but also rediscovery of meaning in life through religion. Negative aspects of religion were suicide attempts following a break with religious communities, suicide attempts with religious delusions and hallucinations, and a wish to die in order to live another life after death.

Substance Abuse

Religion may have influence on persons who abuse substances. In patients with psychosis, we received some indications that religion could provide guidelines that protected them from substance abuse (31). Religious involvement was indeed significantly inversely correlated to substance use and abuse. A content analysis showed that religion may play a protective role toward substance misuse in fourteen percent of the total sample, and in forty-two percent of the subgroup of patients who had stopped substance misuse. It played a negative role in three percent of patients, specifically in those who turned to substance misuse to cope with their spiritual distress after losing their religious communities. Patients' stories indicated the various protective mechanisms of religion against substance misuse or how religion led them to use substances to cope. Conversely, some patients who misused drugs may have been less likely to participate in private and/or collective religious practices than abstinent patients because of social impairment, inappropriate affects and reduced motivation to cope with the outside world brought about by both their illness and substance use and abuse. Some patients with schizophrenia who were drug abusers said they had been rejected by their faith community when they became ill; others said that, even if they could find help and support in religion, they lost contact because of their lack of motivation or because they lost their points of reference.

Patients with Symptoms Involving Religious Content

The fact that patients with psychotic symptoms may entangle religious issues with delusions represents a major challenge for clinicians, keeping in mind that, even in such a situation, these religious issues may be important for their recovery. Religious delusions have been associated with a worse prognosis (32); this issue is controversial, however (11). But what makes delusions with religious content appear in certain individuals? Are they due to biological factors (i.e., specific neurobiological alterations), psychological

factors (e.g., as an attempt to cope with unusual psychological experiences) or social factors (perhaps supported by the fact that the prevalence of delusions with religious content varies across countries and cultures [32])?

Delusions with religious content can be observed in different disorders (e.g., manic episodes, depressive disorders, etc.) but also in various types of delusions. Recent research on medication-free individuals with schizophrenia has indicated that delusions can be separated into three distinct categories: delusions of influence (e.g., delusions of being controlled, thought withdrawal, thought insertion, mind reading, etc.), self-significance delusions (delusions of grandeur, reference, religious delusions of guilt/sin), and persecutory delusions (33). In fact, religious content can be found in each of these categories. Patients may have the conviction that they are being controlled by God or that their thoughts come from God; they may think that they are God; or they may be convinced that they are being persecuted by the devil or some religious figure. This observation provides some evidence that delusions with religious content are unlikely to reflect a unitary phenomenon with a common neurocognitive or neurobiological underpinning. Thus, they should not be considered as a special kind of delusion. Rather, delusions with religious content may be related to former personal and social experiences and, thus, understood within the context of a person's life and culture (34).

Concerning the process of delusion formation and conservation, several factors have been identified. Cognitive factors (such as a bias for "jumping to conclusions," a bias for external attributions and difficulties in thinking about another person's mental state) contribute to mistakes in reasoning (35). The emotions affect the contents in the formation of delusions and the conservation of delusions by reducing emotional tension. For example, blaming others may protect one's self-esteem (36). Another factor lies in the way in which people cope with the turmoil of anomalous experiences of the psychotic state. Delusion is then a rational explanation of an anomalous experience (37). These theories are congruent with a psychoanalytic perspective which considers that delusions hold a symbolic meaning (38). Religion has been conceptualized as a meaning system (39). Thus, delusions with a religious content often occur while the existence of another plane of reality beside the materialistic one—a spiritual or supernatural reality—is an attractive way to give meaning to strange experiences like hearing voices or having personal visions.

The concept of religious delusion could stigmatize patients with psychosis, while hindering the healthy spirituality and religiousness which help many patients recover. Rather than considering "religious delusion," the type of delusion (persecution, influence, self-significance) and the content (religious or not) should be described; this, while waiting for further research on the phenomenology and the neuropathological substrates of these phenomenon.

Religion and Patients' Representations of Illness and Treatment

Recovery involves taking responsibility, including being convinced of the relevance and effectiveness of the treatments offered by clinicians. Patients' treatment and illness representations may influence treatment adherence. For example, illness may be considered as part of God's plan, or as a punishment for a patient's sins. Medication can be viewed as God's gift or as hindering spiritual life (Borras et al. [40]). A study by Mitchell and Romans (41) among bipolar patients highlighted that religious beliefs often conflict with illness paradigms used by mental health professionals and could negatively impact on adherence to treatment. Indeed, thirty-seven percent of bipolar patients saw a link between their religious beliefs and their illness, and thirty-two percent spoke about difficulties because of incompatibility between their faith and the treatment proposed by the caregivers. An example of incompatibility was the intervention of a spiritual leader against medical treatment, advocating spiritual healing as the sole intervention.

The analysis of the patients with schizophrenia in the Borras et al. study (40) found that more than half of the patients had representations of their illness and treatment directly influenced by their religious convictions, positively in thirty-one percent (test sent by God to put them on the right path, a gift from God or of God's plan) and negatively in twenty-six percent (punishment of God, a demon, the devil or possession) (40). Moreover, there was a strong association between representations of illness and treatment, directly influencing, for most of the patients, their spiritual beliefs and nonadherence to treatment. Thirty-one percent of nonadherent patients reported an incompatibility between their religious convictions and medication and supportive therapy, versus eight percent of adherent patients. Content analysis of our data gave some evidence that religion was one of the factors affecting treatment adherence. Through discussion with the patients, we could observe that medical treatment or recommended behavior encouraged by the psychiatrist may enter into conflict with certain teachings of various religious groups. Certain religious groups support spiritual healing exclusively. Taking care of oneself, learning to say no and aspiring toward self-accomplishment may enter into conflict with certain religious teachings. These teachings often encourage service to others and the community, and the subordination of one's personal needs. In other cases, suffering and benevolence may be perceived as favorable.

In developing countries, there may be alternative ways of conceptualizing and treating psychosis (i.e., spiritual healing) that have consequences for illness and treatment representations and should be embedded into recovery perspectives, as these approaches may have both therapeutic dimensions and general life-support benefits. As an example, Duraiswamy et al. (42) showed, in India with a randomized trial, that yoga practice led to improved functioning in terms of symptoms relief and social functioning. Developing countries do not have the monopoly on the attribution of supernatural causes to psychiatric disorders. Pfeifer (43) showed that in a rural area of Switzerland, more than a third of psychiatric outpatient believed that a possible causation of their problems was through the influence of evil. Moreover, thirty percent of patients sought help though rituals such as "prayer for deliverance" and exorcism. In Pfeifer's sample, a positive subjective experience was associated with a calm and reassuring procedure not fixed on demon-induced pathology. Negative experience was related to the strongly dogmatic and coercive attitudes of the healer. Among these patients, those suffering from schizophrenia reported the highest rates of exorcism rituals.

Conversely, some research has shown that mental illness may be recognized as such in developing countries. For example, Younis (44) reported that in Sudan, schizophrenia was identified in seventy-six percent of the cases, both in urban and rural populations. Psychiatric treatment was suggested in more than half of those cases.

In Uganda, Africa, Teuton et al. (45) investigated qualitatively the conceptualization of "madness" across indigenous, religious and "allopathic" healers (i.e., psychiatrists and specialized nurses who have few resources and use mainly psychotropic medications and custodial care). For indigenous healers, "madness" is seen as a sign of a deviation—a form of harm instigated by a jealous party; for religious healers, it is attributed to the influence of Satan.

In Brazil, Redko (46) studied young persons in poor neighborhoods suffering from first episodes of psychosis. Religion allowed them to articulate their personal and interpersonal reactions to psychosis through the use of religious idioms. Religious signifiers were useful to label or describe what they experienced, indicating attempts to cope with psychosis and reflecting the quest for reassuring one's own existence and sense of self. The authors discuss that religion could heal, in terms of what is described above, but also act in a "regressive" manner, for instance when patients remain absorbed by their delusions.

Bilu and Witztum (47) report their experiences in Jerusalem with severely ill, Jewish, ultra-orthodox patients. These patients turn to the clinic as the very last resort, after having attempted—and failed—to employ religious healing. They try to incorporate religiously congruent elements into their secular treatment modalities. The authors found that medications such as antipsychotics, initially ineffective, turned out to be quite potent when accompanied by a religiously informed intervention: " … drugs are presented to create a mystical wall against demonic assault" (p. 228).

Ethnic minority groups may search for spiritual healing when being treated in western countries. Khan and Pillay (48) reported that South Asian patients with schizophrenia living in the United Kingdom gave preference to home treatment, in particular for being able to practice their faith and to have the possibility to add faith healing to their psychiatric treatments. The authors explain these motivations as not only a wish to maintain their cultural identity (an important component of recovery), but also as a means to receive a more holistic treatment.

There appear to be opportunities for dialogue between "modern" psychiatry and religious healers (45). Similar to western countries, this could be accomplished by keeping in mind the principles of recovery, i.e., both psychiatrists and religious healers should admit that patients need a good medication, psychosocial counseling and something more, not only in terms of life goals, but also in terms of a consideration of one's identity, sometimes strongly rooted in religion and culture.

The fact that patients with psychotic symptoms may entangle religious issues with delusions represents a major challenge for clinicians, keeping in mind that, even in such a situation, these religious issues may be important for their recovery.

Clinical Implications

We described how religion/spirituality affects patients with psychosis. But how can we integrate these concepts into treatment? First, as pointed out by Yangarber-Hicks (11), patients' reliance on religious faith and service attendance should not be dismissed as symptoms. Its role as an empowering and recovery-promoting strategy should be encouraged. Also, treatment should focus on religious coping styles when discussing problem-solving strategies.

Going further into discussing how clinicians should consider spirituality/religion with patients suffering from psychotic disorders is not a simple task. The answer depends on various factors, the main one being the cultural context in which clinicians work. Research is still needed on this topic in order to fully address some crucial questions. The first is to know what patients want us to do. Do they wish that we speak with them about religion? We could think that

the answer should be positive, but beyond that, what can we do and what are the issues a clinician could broach with his/her patient? As mentioned before, some issues surely pertain to the clinician, others surely rely on a religious specialist—chaplain or clergy.

If research is lacking on these issues, some elements can give some indirect answers, which are described below.

Individual Treatment

There are specific therapies involving religion, although further research is needed in order to assess their efficacy. For that reason, we focus here on elements which can be considered principally when practicing behavioral-cognitive or supportive therapy with patients with psychosis, according to research on coping and religious involvement.

The first step is to assess the religiousness of the patient (49, 50). Elements of this assessment are detailed in Table 1. Assessment may bring evidence that the patient is not involved in any religious activity, or that he/she invests to some extent in spirituality and/or religion. But spiritual assessment may also put forward problems warranting an intervention. In research on the coping of patients with psychosis, it appears that religion in its personal dimension is not correlated with its social dimension: that many patients believe and pray alone but do not have social contacts related to their faith. In fact, they replicate what happens in other areas, i.e., they have problems creating and maintaining an interpersonal and social network. That is a point which can be a focus of treatment: these deficits should be overcome (or at least try to be) by readaptation or individual counseling. Recovery involves finding activities fitting one's interests. In developed societies, domains of activities (e.g., volunteering, leisure, cultural investments, peer support, etc.) are not easy to find in the long term, particularly when one suffers from residual symptoms. Thus, religious activities should be a part of patients' repertoire (keeping in mind that patients with psychosis may receive a mixed reception by religious groups, depending on the groups' characteristics, as well as on individual patient symptoms).

It may happen that, for various reasons, patients may be in a spiritual crisis (which can occur in the nonpsychiatric population as well). But what is specific to the population of patients with psychosis is that the spiritual crisis may be, to some extent, embedded in delusions or other "bizarre" thoughts. In such cases, clinicians cannot resolve the situation by sending the patient to a chaplain or clergy. A thorough assessment should allow disentangling "true" spiritual crisis from the expression of delusional thoughts. This can be helped by getting the answers to the following questions: Is the patient experiencing a relapse? Is he/she in a moment of his/her life suggesting the possibility of such a crisis? Things can be even more difficult considering the fact that patients may be both symptomatic and in a spiritual crisis. Overall, clinicians should assess and treat—if possible—such situations before addressing a chaplain. In this latter case, a discussion should help the chaplain by giving him/her the

Table 1 Religious and Spiritual Assessment

Religious/spiritual history:	
	family background
	religious education
	significant changes in religious beliefs or practices
Effect of the illness upon spirituality and/or religiousness	
Current spiritual/religious beliefs and practices:	
	religious preference
	spiritual beliefs
	private religious practices
	organizational religious practices
	support from religious community
Subjective importance of religion:	
	in day-to-day life
	to give meaning to life
Subjective importance of religion to cope with the illness:	
	to give meaning to the illness
	to cope with symptoms
	to get comfort
	coping style (self-directing, deferring or collaborative)
Synergy of religion with psychiatric care	

medical context of the patient (with the patient's authorization).

Another point concerns identity and its development. Patients with psychosis also have an identity—and problems related to it—at least partly due to the consequences of the outbreak of their disorder. We described above how patients integrate religious and spiritual dimensions in their illness representation in various cultural backgrounds. Religion/spirituality may be a key component of identity, both in its individual and social parts. Even if most of the therapeutical work with these patients is now behavioral-cognitive based, there now appears some emphasis on psychodynamic issues (7). Depending on the time allowed, and the skills and orientation of the clinicians, it should be possible to integrate these aspects into individual treatment. Work on identity is difficult. A first step is to engage the patient in a narration of his/her story, thus allowing the possibility of reappraising some elements of the patient's identity, including the spiritual/religious components. Further steps may be envisaged, but require a more comprehensive knowledge of the psychodynamic field. Some authors (51) have tried to find ways to work with the religious content of patients with schizophrenia using cognitive behavioral therapy that involves teaching them to recognize the anomalous aspects while still retaining a sense of their value.

In research on the coping of patients with psychosis, it appears that religion in its personal dimension is not correlated with its social dimension: that many patients believe and pray alone but do not have social contacts related to their faith. In fact, they replicate what happens in other areas, i.e., they have problems creating and maintaining an interpersonal and social network.

Another issue pertaining—at least partly—to psychodynamics is the quest of meaning, not from a religious or recovery perspective, but in the sense of understanding one's current reactions and emotions. In the field of religion, a patient could gain some knowledge as to why he/she invests God as a paternal figure in the light of his/her relation with his/her parents. Different studies suggest higher levels of insecure attachment in patients with psychosis as compared to controls (52). A pilot research study investigating attachment styles and spiritual coping in patients with psychosis (53) identified a relationship between patients' compensation strategies in the process of constructing affectional security and spiritual beliefs. The first analyses suggest that patients reproduce interpersonal parental experiences within the context of a relationship to a spiritual figure, which is associated with a compensatory coping strategy.

As mentioned below, all these interventions should be brought together under the common concept of recovery. In particular, individual treatment should help to provide culturally sensitive treatments, emphasizing consumer choice and addressing barriers to access.

Clinical Implications in Terms of Group Therapy

Rehabilitation is often implemented in order to move toward recovery. However, consumers have reported that the services they received were least helpful in achieving goals in spiritual and religious domains (54). Nevertheless, group activities have been developed beyond individual treatment in some places, mostly in the United States. The group format has some advantages as compared to individual treatment in terms of costs, as well as in terms of the possibilities for patients to interact.

Kehoe (55, 56) has been a pioneer in the field, having conducted such a group for decades. This activity consists of weekly sessions involving ten to twelve patients for, in general, two to three years. The group's aims include fostering tolerance, self-awareness and nonpathologic therapeutic exploration of value systems. Patients are first asked to describe their current religious tradition or spiritual quest through interactions. They are given an opportunity to consider their beliefs in terms of helping their recovery and/or how those beliefs may create conflicts. To our knowledge, no outcome study has been conducted on these groups, but the author emphasizes that no patient has ever decompensated either in the group or because of it.

Phillips et al. (57) developed a program, defined as semistructured, providing through seven weekly sessions information on specific topics such as spiritual resources, strivings and struggles, followed by discussions. These discussions were often intense, involving topics such as the way that mental illness had interfered with patients' achievement of striving, the sharing of spiritual struggles and the merits of forgiveness. Based on a sample of ten subjects, Phillips et al. concluded that this intervention appeared to reach most of its objectives, and most patients expressed that they wanted the group to continue.

Wong-McDonald (58) described the outcome of an optional spirituality rehabilitation program, as compared with an ordinary program. This spirituality group, added to a psychosocial rehabilitation program, consists of discussing spiritual concepts, encouraging forgiveness, listening to spiritual music and encouraging spiritual and emotional support among members. This add-on program allowed one hundred percent of patients to achieve their goals versus

fifty-seven percent of patients receiving the usual treatment. Unfortunately, no additional outcome data were measured.

Revheim and Greenberg (59) developed for hospitalized patients the "Spirituality Matters Group" (SMG), which follows the rationale that spiritual support fosters the recovery process. SMG aims at offering comfort and hope through structured exercises focusing on spiritual beliefs and coping. These exercises involve more specifically religious-oriented activities, such as readings from the book of Psalms and reciting and writing prayers, combined with cognitive-oriented activities such as emotion-focused coping. Created in the United States, this group is conducted both by clinicians and pastoral caregivers. It involves a mix of psychological and religious features, which may be cautiously implemented in other areas, such as Europe, at least in public facilities. The developers of this group are now planning research on its potential treatment mechanisms and outcome.

Overall, according to the literature, group activities involving spirituality are burgeoning, at least in the United States. Most of them aim at fostering patients' religious investment, thus being part of the recovery process. But the development of such activities warrants a careful evaluation of the social and cultural context in which they are implemented. Also, further research is needed in order to assess their impact in terms of recovery, quality of life and symptoms.

Conclusions

Psychosocial treatments still remain the cornerstone of the treatment of patients with severe mental disorders such as schizophrenia. There is now some consensus that recovery should be the organizing principle of care for these patients. Among other issues, such as the support of consumer self-sufficiency, the encouragement of the utilization of advance directives and the addressing of barriers to access, religion and spirituality should play an important part in the recovery process. Lukoff (60) considers recovery from a mental disorder as part of one's spiritual journey. Even if research is still needed in this particular field, it seems obvious that psychiatrists and other clinicians involved with patients with schizophrenia should bridge the gap involving patients' religious background and religious communities.

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