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Introduction of Spiritual Psychotherapy for Inpatient, Residential, and Intensive Treatment (SPIRIT) in The Netherlands: Translation and Adaptation of a Psychotherapy Protocol for Mental Health Care

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Abstract: The perceived value of the integration of spirituality and religion (SR) in mental health care is growing. This study aimed to adapt an SR intervention developed in the USA (SPIRIT) for use in the Netherlands and to explore its applicability. Employing a participatory practice-based action research design, professionals, clients, and an advisory board collaborated in iterative cycles of translation, adaptation, discussion, and testing. The ongoing interfaith dialog during the adaptation process broadened the perspectives incorporated into the existing handouts. We added the term “meaning” (M) alongside SR to accommodate patients who do not identify with religion or spirituality. Additionally, several handouts were added to the original protocol: autonomy, responsibility, and liberty; loneliness and belonging; inspiring persons in the past and present; and grief and loss. Moreover, the existing handout on sacred verses was expanded to encompass versions from various outlooks on life: philosophical/humanistic, Judeo-Christian, Buddhist, Islamic, and Hindu. Finally, layout modifications and diverse exercise formats were introduced. A qualitative examination revealed that the adapted SPIRIT protocol was well received by professionals and patients, and quantitative studies on its applicability and usefulness are recommended.

Keywords: SPIRIT; intervention; translation; adaptation; mental health care

1. Introduction

Globally, there is an increasing recognition of the value of integrating religion and spirituality (SR) into mental health care. While SR are now acknowledged as essential factors in (mental) health (Huber et al. 2016; Moreira-Almeida et al. 2016), there is also a growing interest in integrating SR into healthcare. Systematic reviews provide tools for

taking an SR history, such as FICA, SPIRITual History, FAITH, and HOPE (Lucchetti et al. 2013). Others have developed and tested specific SR-integrated interventions, such as SR-integrated cognitive behavioral therapy (Koenig et al. 2016) or SR-integrated acceptance and commitment therapy (Santiago and Gall 2016). Multiple meta-analyses demonstrate the effects and benefits of integrating SR into mental healthcare, indicating that it enhances standard care (Anderson et al. 2015; Bouwhuis-Van Keulen et al. 2023; Captari et al. 2022; Gonçalves et al. 2015).

Recently, Rosmarin and colleagues developed Spiritual Psychotherapy for Inpatient, Residential, and Intensive Treatment (SPIRIT, Rosmarin et al. 2019), designed for acute psychiatry settings. SPIRIT is a group psychotherapy based on a CBT framework, including a psycho-education component, as well as specific tools or skills drawing on spiritual concepts or beliefs (cognitions) and activities (behaviors) that patients can use to shape their emotional experience. In the U.S., this form of therapy has been very well received by patients and is considered beneficial (Rosmarin et al. 2021). A majority of patients with various diagnoses reported that SPIRIT helped them to identify spiritual and religious resources to aid their recovery. Among patients who reported significant spiritual distress, most reported that SPIRIT helped them to identify spiritual and religious struggles that were contributing to their distress.

A distinctive aspect of this intervention is its development for acute and inpatient care settings. While existing interventions are often utilized in ambulatory care, research indicates that patients undergoing intensive mental health treatment in inpatient settings or similar environments may have a heightened need for SR care (Fitchett et al. 1997; van Nieuw Amerongen-Meeuse et al. 2020). This is relevant; especially, religious coping is all the more important in stress situations such as mental illness and is related to mental health (Pargament et al. 2000). Therefore, focusing on this group appears to be useful.

In the Netherlands, SR-integrated therapy is still in its early stages. The country is secularized, allowing individuals to shape their outlook on life as they prefer. Many people seek meaning from various SR traditions (Bernts and Berghuijs 2016; Braam and Verhagen 2022), amid the presence of multicultural influences. New existential, ethical, and spiritual languages are emerging, alongside the persistence of traditional life perspectives (Anbeek 2017). Simultaneously, the need for SR-integrated therapy is established in research (van Nieuw Amerongen-Meeuse et al. 2020) and in guidelines, exemplified by the recent Practical Guideline “Meaning and Spirituality in Dutch Mental Health Care” (Akwa GGz 2023), which emphasized the importance of SR-sensitive and integrative care for individuals dealing with mental health problems. These facts underscore the significance of identifying suitable SR methodologies for Dutch mental health care. It seems reasonable to explore whether an existing and widely accepted intervention from a country in the Global North, such as SPIRIT in the U.S., could be adapted effectively for use in the Netherlands. Consequently, our research aimed to adapt SPIRIT to Dutch culture and to explore its applicability within the context of clinical mental health care in the Netherlands. This endeavor will involve meticulous attention to adapting and supplementing the existing protocol. Our approach encompassed a participatory practice-based action design, including three elements: a topical analysis (1), a detailed investigation of content (2), and an examination of layout (3).

2. Materials and Methods

The adaptation of the SPIRIT protocol took place in the Netherlands, in cooperation between the Center for Research and Innovation in Christian Mental Health Care; and two mental health care institutions: Altrecht, Mental Health Care; and GGz Centraal, Mental Health Care. In addition, an advisory board was available for consultation during the project Prof. H. Schaap-Jonker, Vrije Universiteit Amsterdam; Prof. A.W. Braam, University of Humanistic Studies, Utrecht; Prof. P.J. Verhagen, KU Leuven (Belgium), and prof. R. Hoenders, University of Groningen.

2.1. Research Design

We used a participatory practice-based action research design. Participatory action research is a form of implementation research (Theobald et al. 2018), a type of research that is essential for creating successful interventions (Handley et al. 2016). In action research, change, learning, and knowledge development go hand in hand. Action research is participatory, cyclical, and reflexive (Baum et al. 2006). In healthcare research, participatory action research is used by communities of health care professionals to reflect on and improve their own practice (Cornish et al. 2023). Four key principles are central: (1) the authority of direct experience, (2) knowledge in action, (3) research as a transformative process, and (4) collaboration through dialog. For action research, six building blocks have been proposed: building relationships; establishing working practices; establishing a shared understanding of the issue; observing, gathering, and generating materials; collaborative analysis; and planning and taking action (Cornish et al. 2023).

2.2. Procedure

In the current study, the six building blocks were employed in various ways and in a flexible order. The adaptation of the SPIRIT protocol occurred through an iterative process, continuously supervised by the advisory board. Several focus groups with patients were conducted, and a collaborating working group comprising multidisciplinary members of the project group (psychiatrists, psychologists, spiritual counsellors, nurses, and clients) discussed the relevant issues in an interfaith dialog. During these group sessions, there was an open and constructive exchange of thoughts, ideas, and beliefs among representatives of different religions or faith traditions. The focus was on exploring common values, discussing various religious perspectives, and finding ways to shape the protocol constructively despite diverse worldviews.

In June 2022, David Rosmarin presented SPIRIT at the European Conference of Religion, Spirituality, and Health (ECRSH) in Amsterdam (see also Kaufman et al. 2022). Subsequently, several attendees at the conference deliberated on the potential of SPIRIT for the Netherlands, leading to the formation of a project group (*building relationships*). This group was established based on the collectively perceived need to develop and adapt this SR intervention for use in the Dutch mental health care.

Between June and November 2022, several meetings were held with the project group, the advisory board, international collaborators, health professionals, and clients (*establishing working practices and a common understanding of the issue*). An overview of the different group sessions and their participants is presented in Table 1. We explored whether SPIRIT could be an appropriate intervention and discussed its implementation in Dutch treatment practices. All the meetings were meticulously documented. In December 2022, a professional translator translated the SPIRIT protocol into Dutch, and between January and March 2023, several SPIRIT test groups took place, repeatedly, in three different mental health care institutions: Eleos, de Hoop and GGz Centraal (*taking action*), reflecting the principles of “the authority of direct experience” and “knowledge in action” in practice.

We evaluated the SPIRIT test groups between February and November 2023 through focus groups with clients and evaluations with caregivers of De Hoop ggz and of GGz Centraal (*observing, gathering, and generating materials*). The questions asked in these groups were as follows: What are your experiences with the SPIRIT module? Could you elaborate on this a bit more? Were there aspects that you found challenging during the group sessions? How was it after the sessions? How were your experiences in comparison to other modules? Do you have any suggestions for improvement or additional insights? Apart from the minutes of the meetings, which included quotes, no data were collected from the participants. Verbal consent was obtained in each focus group to use the quotes for the purpose of writing scientific texts. During the same period, several developmental groups were organized with clients, experts by experience, team managers, practitioners, and spiritual counselors of [Altrecht, GGz Centraal, Eleos and de Hoop ggz (*generating materials, planning, and taking action*)]. Additionally, a task force consisting of members of the project

group came together three times to collectively refine the SPIRIT protocol with ongoing discussions. Between September and November 2023, the final steps in the adaptation of the SPIRIT protocol were taken, and the current paper was written (*collaborative analysis, planning, and taking action*). The process as a whole—and the way we filled in the building blocks—is illustrated in Figure 1.

Table 1. Different groups cooperating to adapt the SPIRIT protocol.

	Total Project Group	Advisory Board	Caregiver Evaluations	Patient Focus Groups	Working Group
Members	Multidisciplinary group: psychologists, psychiatrists, nurses, clients, spiritual counselors, academics	Prof. Dr. Arjan Braam Prof. Dr. Peter J. Verhagen Prof. Dr. Hanneke Schaap-Jonker Prof. Dr. Rogier Hoenders Dr. David H. Rosmarin	Caregivers providing test SPIRIT groups	Patients of Christian and secular institutions	Two spiritual counselors Nurse specialist Psychiatrist Researcher
N	10–15	3–5	2–3	4–6 per group	5
Meetings	23 June 2022 18 October 2022 27 March 2023 8 May 2023 30 August 2023	8 July 2022 12 September 2022 14 November 2022 27 November 2023	10 February 2023 30 March 2023	11 April 2023 23 June 2023 30 November 2023	5 July 2023 13 September 2023 11 November 2023

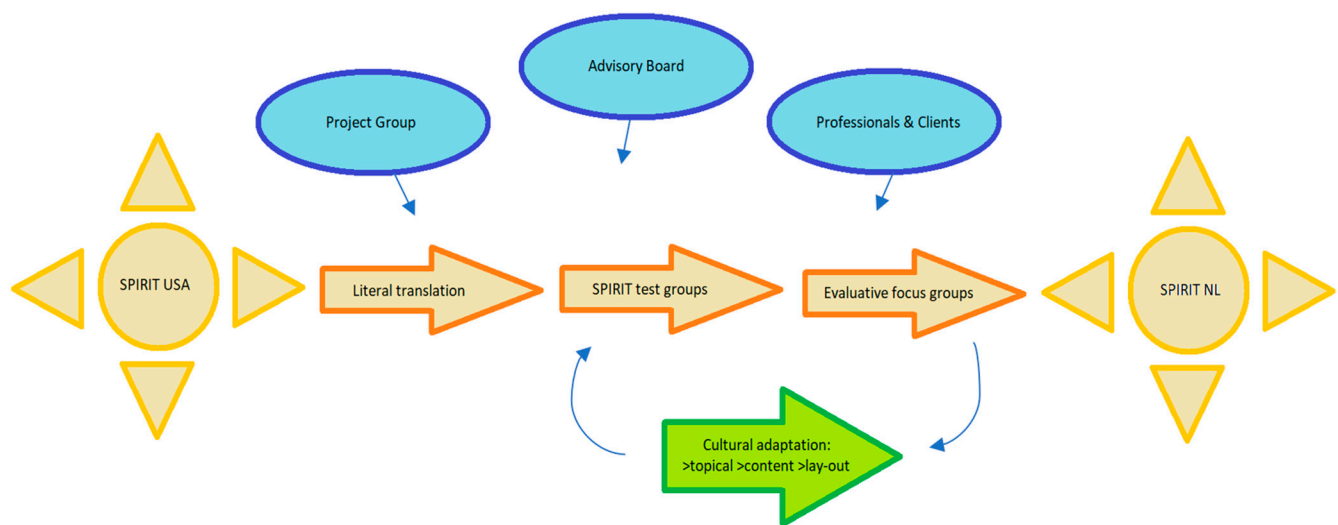


Figure 1. Process of translation and adaptation of the SPIRIT protocol.

2.3. Analysis

In participatory action research, data collection and analysis typically occur simultaneously. In the current study, analysis occurred iteratively throughout the research period. The test SPIRIT groups that used the literal translation of the protocol were evaluated and analyzed. Results were discussed in the different meetings with the research group and advisory board, based on which the protocol was modified and retested. Two members of the research group (BvdB and JvNA) collected material by means of caregiver evaluations and patient focus groups in response to the question of how well the translated SPIRIT protocol met expectations. They then convened with the working group to critically discuss its significance and propose modifications. To describe the action research process, all the gathered material was thoroughly read and reread by two authors independently. They developed core themes as a means of defining the main points to describe the adaptation process, forming the basis for the results section. The first author drafted the results

section, which was subsequently discussed and adapted. Following this, the entire team of community representatives had the opportunity to supplement and adjust the results as needed.

3. Results

Translating a cognitive behavioral intervention developed in another country and culture must be approached with care, as it will lead to adjustments in the intervention protocol. In the initial SPIRIT test groups and discussion groups, we used the verbatim translated SPIRIT protocol. However, it became evident early on that more than a literal translation was necessary, although patients did not react negatively to the SPIRIT intervention. In this section, we will (1) discuss the initial reception; (2) elaborate on the process of adaptation, subdivided into (a) content evaluation, (b) topical evaluation, and (c) examination of language and form; and (3) address the secondary reception.

3.1. Initial Receipt

The project group at the conference expressed enthusiasm for SPIRIT, which was presented as an interfaith intervention designed to integrate SR into acute mental health care settings. It was described as flexible and was well received by diverse groups of patients. The initial settings for SPIRIT testing in the Netherlands involved two Christian clinics. One clinic chose to exclude all “non-Christian” religious texts from the handouts, while the other decided to keep all perspectives from various outlooks on life in the protocol. In both institutions, the reception was positive. Patients mentioned that they appreciated the space to discuss things of ultimate importance. A patient who attended seven sessions, each focusing on one of the seven different original handouts, remarked the following:

“I liked it very much. Of all the modules, I find this one the most profound. Also, to incorporate religion [. . .] also when dealing with suicidal thoughts, and contemplating the meaning of everything, yes, faith is a significant source of strength for me. Sometimes, it’s the only thing I still derive strength from” (woman, test SPIRIT group original protocol, Christian institution).

Another patient reported some resistance to the groups, stemming from negative experiences in his previous religious context. However, he had decided to keep on joining the groups and could recognize himself best in the handout “religious and spiritual struggles”. A third patient mentioned difficulties with the handout “forgiveness”, which stirred up a lot for her. Patients in one of the secular institutions that participated were also enthusiastic about SPIRIT:

“Why has this not yet been further disseminated?” (man, test SPIRIT group original protocol, secular institution).

The patients had few objections to the literally translated SPIRIT protocol, but the caregivers reported some reservations. Both caregivers and spiritual counselors in the two secular settings reported difficulty with the content of several handouts that seemed explicitly religious to them. In particular, the handout on psalms was not well accepted, even though the protocol clearly stated that the handout would only be appropriate for Judeo-Christian populations. There was difficulty with an experienced normative framework, resistance to lengthy texts, and a need for more room for patient input.

While patients, in general, did not express negativity, they highlighted diverse themes across the test groups that could be incorporated into the protocol, such as freedom versus responsibility, loneliness, and grief. This was sustained by caregivers. The caregivers also recommended adopting a broader range of perspectives on life commonly found in the Netherlands. Additionally, the caregivers advised developing creative ways of working with the handouts, by reason of the patients’ conditions and the desire for variation. One of the caregivers reported that patients could also expect too much from the intervention or that others were not able to apply the tips to themselves.

This feedback initiated the adaptation process.

3.2. Adaptation Process

The adaptation process could be divided into three parts, although these did not take place sequentially but simultaneously: the adaptation of content (a), the addition of topics (b), and the modification of the layout (c). The results of this process are shown in Table 2.

Table 2. Adaptation of SPIRIT to Dutch culture: handouts of SPIRIT USA and SPIRIT NL.

SPIRIT USA	SPIRIT NL
(1) Philosophical beliefs and reframes	(1) Philosophical beliefs and reframes
(2) Meaning and coping in treatment	(2) Meaning and coping in treatment
(3) Spiritual/religious struggles	(3) Spiritual/religious and meaning struggles
(4) Inspiring verses	(4) Inspiring verses from ...philosophical/humanistic views (a) ...Judeo-Christian views (b) ...Buddhist views (c) ...Islamic views (d) ...Hindu views (e)
(5) Meditating on the Psalms	(5) Autonomy, responsibility, and liberty
(6) The power of prayer	(6) Loneliness and belonging
(7) Forgiveness	(7) Inspiring persons in the past and present
	(8) The power of meditation and prayer
	(9) Grief and loss
	(10) Releasing and forgiveness

3.2.1. Content

The ongoing interfaith and multidisciplinary dialog during the adaptation process resulted in the addition of more diverse views and insights into the existing handouts. Both spirituality and religiosity are not terms with that most of the Dutch population identify with (Braam and Verhagen 2022), and meaning in life is considered a more neutral term for issues of ultimate importance, making sense and giving purpose to someone's life (La Cour and Hvidt 2010). The research team, therefore, decided on the structural addition of the word "meaning" (M) to spirituality/religiosity (SR), elaborated by the consistent use of MSR instead of SR.

Handout 1/1 (the first number representing SPIRIT USA and the second number representing SPIRIT NL) was enriched with the idea "You are not your illness, you are a unique person", along with a corresponding elaboration. Handout 2/2 was supplemented with encouragements to be inspired by art, find space in nature, or choose an activity that makes someone happy. A word cloud was added to handout 3/3. Furthermore, our team decided to expand the optional handout 4 (USA) on the Psalms to include a wider variety of worldviews by merging it with handout 5 (USA) "sacred verses" and then breaking it down by worldview. Although the handout on Psalms was presented as optional for groups for which it was appropriate in the original protocol, in regular settings, the handout structurally met considerable resistance from secular professionals. The current merged handout 4 (NL), which we named "inspiring verses", allows professionals to offer suitable handouts to patients with various outlooks on life, without one specific worldview standing out. This offers patients the possibility to draw inspiration from different worldviews without having to choose one of them. The "sub"-handouts were created by consulting spiritual counselors and others who adhere to various outlooks on life, involving handouts from Hinduism, Buddhism, Islam, and a more humanistic/philosophical approach. The original Judeo-Christian version of handout 4 was broadened by adding other Bible verses alongside the Psalm quotes.

Handout 6/8, about prayer, was made somewhat broader by adding the option to meditate, considering that many patients might not be accustomed to praying but could be familiar with or open to meditation. Additionally, the handout about forgiveness, numbered 7/10, was extended to include "release", incorporating insights from the work

of Edith Eva Eger. This expansion broadens the concept of forgiveness and provides tools that can directly address various everyday life situations.

3.2.2. Topics

The existing SPIRIT protocol, which comprised cognitive and behavioral elements, included seven handouts, as presented in Table 1. In the various evaluative groups, several topics emerged that were added to the original protocol, through the creation of extra handouts. After the process of topical evaluation, the new Dutch SPIRIT protocol, still consisting of behavioral and cognitive elements, now includes 10 handouts and several “sub-handouts”. All three new handouts are briefly discussed here, and can be found completely in in the Supplementary Materials.

Autonomy, responsibility, and liberty (5). This topic is related to one’s outlook on life: the extent to which life can be shaped and the level of control over one’s “destiny” and determinism. Regardless of how one perceives the degree of freedom an individual has to make choices, and illness always brings with it a sense of unfreedom. Opportunities to arrange one’s own life become limited. At the same time, patients are often asked to express their own preferences and needs. The handout provides space to engage in a conversation about the extent to which one feels responsible for their own recovery, to discuss the freedom to make choices, the limitations experienced in doing so, and the importance of cooperation with others.

- Text fragment:

“Have you ever wondered how achievable life is? To what extent are you responsible for your own recovery? Are you always free to make the choices you want to make? Illness brings about a lack of freedom, where the ability to shape your own life becomes limited. Yet, you are often expected to articulate your desires. Stepping back might be beneficial. What beliefs do you hold about freedom, autonomy, and responsibility? Here, a series of questions and answers are listed. Which ones are helpful, and which ones would you prefer to let go of?”

Loneliness and belonging (6). The content of this handout has been crafted on the premise that every human being needs love and possesses the ability to give love. Loneliness revolves around individuals not feeling seen, heard and loved. Mental illness often brings about loneliness in some form: either existing beforehand or resulting from the challenges posed by the illness. Furthermore, patients may encounter difficulties in loving themselves, which could be seen a crucial aspect for experiencing connection with others. These topics and their corresponding discussions are explored in the current handout.

- Text fragment:

“Every person has a need for love and the capacity to give love. Loneliness arises from not feeling seen, heard, or loved. Mental issues can result from missed love, yet they can also cause the absence of love because we may function differently than usual. Often, it is challenging to love ourselves. However, that’s a crucial key to experiencing love from others and being able to love others. Discuss the love you feel you’re missing or have missed. Identify from whom you have experienced or still experience love. Then choose one of the following texts, and consider why and how you can love yourself. Why is this important?”

Inspiring persons in the past and present (7). From birth, people live with role models—individuals they imitate. Even in adulthood, there are still people you admire, thinking: ‘I would like to be like that too’. This handout provides space to reflect on this topic. It can be helpful to focus on the characteristics of another person that you find admirable, allowing you to see more clearly what you yourself would like to strive for in your own life.

- Text fragment:

“No one lives without examples. Of course, your father and mother can be examples, or quite the opposite. Others from your own neighborhood, family, or ancestry can also serve

as examples, like a neighbor, grandmother or grandfather, uncle or aunt, or ancestor. Role models are often positive examples. Sometimes, they also show how not to do things and how you never want to be. Many well-known individuals are also examples for many. Often, they represent ways of dealing with difficulties and problems.”

Grief and loss (9). With life comes loss, the relinquishing of what a person once cherished. When people experience mental health problems for an extended period, they undoubtedly lose people or things that were important to them. Unfortunately, this aspect is often not discussed. Yet, it can be beneficial to reflect on what a person has lost. Although professionals cannot compel a grieving process, we believe it is essential to create space for it. This handout provides an opportunity to reflect on this and share experiences with others, allowing the group to also contemplate what each individual needs.

- Text fragment:

In life, there is also loss, the letting go of what you once cherished. When you have been dealing with mental health issues for a while, undoubtedly, you have lost people or things that were important to you. Unfortunately, this aspect is often not discussed. However, taking a moment to reflect on and identify what you have lost can be helpful.

What have you lost? These can be very different things. Try to write down two significant things that you have lost for yourself. A few examples of what people might have lost due to mental health issues include the ability to pursue the career they wanted, a group member who left and never contacted them again, someone who died by suicide, dreams for the future, hope for a better future, the ability to feel and enjoy things, concentration, sleep or interest in the day.

3.2.3. Layout and Form

In addition to all the content changes, we made efforts to enhance the document to make the protocol more user-friendly and provide a clearer overview. Consequently, we added a table of contents and created different sections. Where possible, we simplified the language. Additionally, a list of useful work formats was incorporated to allow group leaders to introduce more variety to the processing. We referred to the initial presentation of SPIRIT groups as “original” and included ideas for using excerpts, two-way discussions, personal contributions, or digital processing. The document became more colorful and the formatting slightly less concise, while maintaining the original format of the sessions unchanged.

3.3. Secondary Receipt

After the adjustments, the protocol was sent to all the involved parties. The reactions were positive:

“I appreciate the playfulness of the word cloud, the pinboard, and the card game. It makes it more interactive and requires participation as a group or participant to engage in thinking. It also seems to have expanded with more than just the usual philosophies, which I think will appeal to a lot of people” (patient, secular institution, adapted protocol).

The modified protocol was also tested in a group session within an acute psychiatric day-treatment setting. Subsequently, the experiences of the participants and reactions to the protocol were collected. The feedback was unanimously positive. They requested a permanent place for this group in the day-treatment program. Some quotes from this evaluation were as follows:

“This really resonates with me” (patient, secular institution, adapted protocol).

“I often contemplate the meaning of life in my current situation” (patient focus group secular institution, adapted protocol).

“After participating in this group, I feel that my time is better spent here than in the psycho-education group twice a week” (patient, secular institution, adapted protocol).

Patients appreciated the SPIRIT group because it was really about themselves and because they expected more or less to have this kind of therapy, whereas until now this was not present.

4. Discussion

In recent years, mental health care has witnessed a development in therapeutic approaches, with growing attention being paid to the potential role of spirituality and religion (SR) in promoting wellbeing and recovery (Fallot 2007; Koenig 2009; VanderWeele 2017). In this context, there has been a perceived need to facilitate attention to SR within the context of mental health care in the Netherlands.

The decision was made to translate and adapt an existing intervention developed in the USA, named SPIRIT, which was well received there (Rosmarin et al. 2021). This process posed several challenges. Despite both the USA and the Netherlands being countries in the Global North, there are significant differences in terms of religious diversity and how individuals deal with it. Indeed, various professionals in the field expressed reservations, stating that the protocol seemed quite religious to them. Perhaps, remnants of the “religiosity gap” played a role here (Lukoff et al. 1992). Secularization processes and life in a post-Christian culture may contribute to resistance against religion (Paas 2012). Interestingly, non-religious patients did not report this resistance. In addition, resistance to religion is not experienced by everyone, as seen in the research by Kruijthoff, which sparked many societal discussions (Kruijthoff 2023). It is quite conceivable that from the professionals’ perspective, there is a fear of imposing a certain belief system on patients, although the protocol explicitly states otherwise. Respecting autonomy, cultural diversity, and individual beliefs remains crucial to ensure inclusive and respectful interventions.

Adjustments, both in content and terminology, were necessary. The existing handouts have been expanded to incorporate the most prevalent ideologies in the Netherlands (CBS 2020). Additionally, we included several existential themes in line with the existential anxieties of freedom, death, isolation, meaninglessness, and identity, as described by Yalom, Glas, and others (Yalom 1980; Glas 2003; van Bruggen et al. 2015). Autonomy and liberty are topics of discussion regarding the use of coercion (Hem et al. 2018), but they may also be recognized as existential themes in a broader sense. Loneliness is strongly related to (worse) mental health outcomes (Heinrich and Gullone 2006), but it also relates to worldview and religious/spiritual activities that can provide a sense of belonging. Inspiration has been argued to be a distinct psychological construct crucial to humans. Thrash and Elliot (2003) propose that cultivating and developing it, as well as being inspired by others, provides us with transcendence, enhancing our wellbeing and capacity to achieve. In that context, the handout about inspiring individuals fits. Finally, the handout about grief and loss focuses on changes as a cause or result of mental illness, which has more often been a topic of study (Brijan 2020). The added handouts address various themes of existential anxiety (van Bruggen et al. 2015), but they also provide the opportunity to explore pathways of Connectedness, Hope, Identity, Meaning, and Empowerment (CHIME) and routes to mental health recovery (Hare-Duke et al. 2023).

Notably, certain terminology required adaptation; hence, “spirituality” or “religion”, which does not resonate with everyone in the Netherlands (Bernts and Berghuijs 2016), lead to the inclusion of “meaning,” acknowledging the broad spectrum it encompasses, at times blurring the lines with R/S (La Cour and Hvidt 2010). The lack of meaning is part of several mental health issues (e.g., personality disorders, suicidality). Despite this, adding this aspect seemed justified, given that “meaning in life” aligns with “the sacred,” for individuals regardless of their religious or spiritual inclinations (Park 2005). SPIRIT NL aims to help individuals find meaning, resilience, and a sense of purpose amid mental health challenges, potentially contributing to their overall psychological wellbeing. In addition, offering a variety of worldviews can contribute to a (re)consideration of one’s own basis for meaning in life, if desired, providing patients with a multitude of

options. The group discussions can be meaningful, provided the condition of respecting all worldviews is maintained.

Following substantive adjustments to the protocol, patients, professionals, and academics positively evaluated it, expressing confidence in its capacity to help patients by actively integrating their beliefs into their treatment trajectory. Nonetheless, this warrants further consideration, as integrating SR interventions alongside conventional treatments in mental health care may spark discussions within academic and clinical realms. To what extent is it a mental health professional's responsibility to engage in these subjects? Does it encroach upon the territory of a spiritual counselor? Role confusion may arise but is not necessary. SPIRIT, being based on CBT, necessitates delivery by a mental health professional trained in this approach. While professionals should be trained in integrating SR interventions, it does not entail a crash course in spiritual care and chaplaincy. Instead, the intervention can serve as a bridge to spiritual care, fulfilling a long-standing demand as sometimes spiritual care and mental health care operate distinctly, causing confusion for patients. Additionally, recovery encompasses a broad concept, including existential and personal recovery, which are essential elements of mental health. In this way, it could be considered the responsibility of every mental health professional (Schaap-Jonker 2022). Clear delineation and effective communication can ensure that SPIRIT meets patient needs without professionals encroaching upon spiritual counselors' roles.

Despite the positive evaluation by those involved in the current study, it is important to note a caveat. Religion can, in some cases, be harmful to or painful for patients (Pargament and Lomax 2013) and religious struggles may impede recovery processes (Koenig 2009). While Rosmarin describes that SPIRIT can help address and work through religious struggles (Rosmarin et al. 2021), it is not guaranteed that this will apply to everyone, and consideration should be given to the fact that attention to SR may also be challenging for some individuals. It is advisable to address possible adverse effects in future research.

Critics argue that clinical guidelines to integrate SR into practice suffer from a lack of empirical evidence and are more opinion-based than evidence based (Poole and Higgs 2011; Poole 2020). The subjective and diverse nature of spirituality poses challenges in standardizing interventions, potentially hindering reproducibility and generalizability in clinical settings. However, review articles demonstrate benefits from SR-integrated therapy (Bouwhuis-Van Keulen et al. 2023; Captari et al. 2022). While it is desirable to study the effectiveness of SR interventions and whereas the clearness of evidence for SPIRIT could be further investigated, some argue that not everything that can be counted counts, and not everything that counts can be counted (Cameron 1963). Furthermore, the current project aligns with various recommendations outlined by the WPA (Moreira-Almeida et al. 2016), including the tactful consideration of a patient's SR, the incorporation of diverse cultural backgrounds, the acknowledgement of potential benefits and harm from SR, and the preservation of respect for various outlooks on life. Striking a balance between acknowledging SR as a crucial aspect of mental health and a rigorous evidence-based approach remains essential.

Subsequent research should take into account the importance of empirical validation and ethical considerations within a holistic approach. It remains crucial to strive for a nuanced approach that respects diverse beliefs, integrates evidence-based practices, and upholds ethical standards. SPIRIT presents promising opportunities and encourages the exploration of possibilities to investigate the effectiveness of this intervention concerning psychological, societal, and existential wellbeing and recovery in acute psychiatric settings and beyond. Academic research combined with clinical wisdom is essential to comprehend the complexity and harness the potential of spiritual interventions like SPIRIT to enhance outcomes in mental healthcare.

Supplementary Materials: The following supporting information can be downloaded at <https://www.mdpi.com/article/10.3390/rel15030253/s1>. English translation of the Dutch-adapted SPIRIT protocol.

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References

- Akwa GGz. 2023. Generieke module Zingeving in de psychiatrische hulpverlening. [Practical guideline ‘Meaning & Spirituality in Dutch Mental Health Care’]. Available online: <https://www.ggzstandaarden.nl/zorgstandaarden/zingeving-in-de-psychische-hulpverlening> (accessed on 10 August 2023).
- Anbeek, Christa W. 2017. World-viewing dialogues on precarious life: The urgency of a new existential, spiritual, and ethical language in the search for meaning in vulnerable life. *Essays in the Philosophy of Humanism* 25: 171–85. [CrossRef]
- Anderson, Naomi, Suzanne Heywood-Everett, Najma Siddiqi, Judy Wright, Jodi Meredith, and Dean McMillan. 2015. Faith adapted psychological therapies for depression and anxiety: Systematic review and meta-analysis. *Journal of Affective Disorders* 176: 183–96. [CrossRef]
- Baum, Fran, Colin MacDougall, and Danielle Smith. 2006. Participatory action research. *Journal of Epidemiology and Community Health* 60: 854–57. [CrossRef] [PubMed]
- Bernts, Ton, and Joantine Berghuijs. 2016. *God in Nederland 1966–2015 [God in the Netherlands 1966–2015]*. Utrecht: Ten Have.
- Bouwhuis-Van Keulen, Annette J., Jurriijn Koelen, Liesbeth Eurelings-Bontekoe, Christien Hoekstra-Oomen, and Gerrit Glas. 2023. The evaluation of religious and spirituality-based therapy compared to standard treatment in mental health care: A multi-level meta-analysis of randomized controlled trials. *Psychotherapy Research: Journal of the Society for Psychotherapy Research* 1–14. [CrossRef] [PubMed]
- Braam, Arjan W., and Peter J. Verhagen. 2022. Levensbeschouwelijke diversiteit: Mozaïek en dynamiek. *Tijdschrift voor Psychiatrie* 64: 535–39. [PubMed]
- Brijan, Bernice. 2020. Existential loss in the face of mental illness: Further developing perspectives on personal recovery in mental health care. *Phenomenology and Mind* 18: 250–58. [CrossRef]
- Cameron, William B. 1963. *Informal Sociology: A Casual Introduction to Social Thinking*. New York: Random House.
- Captari, Laura E., Steven J. Sandage, and Richard A. Vandiver. 2022. Spiritually integrated psychotherapies in real-world clinical practice: Synthesizing the literature to identify best practices and future research directions. *Psychotherapy* 59: 307–20. [CrossRef] [PubMed]
- CBS. 2020. Religie in Nederland. Available online: <https://longreads.cbs.nl/nederland-in-cijfers-2020/welk-geloof-hangen-we-aan/> (accessed on 28 November 2023).
- Cornish, Flora, Nancy Breton, Ulises Moreno-Tabarez, Jenna Delgado, Mohi Rua, Ama de-Graft Aikins, and Darrin Hodgetts. 2023. Participatory action research. *Nature Reviews Methods Primers* 3: 34. [CrossRef]
- Fallot, Roger D. 2007. Spirituality and religion in recovery: Some current issues. *Psychiatric Rehabilitation Journal* 30: 261–70. [CrossRef]
- Fitchett, George, L. A. Burton, and A. B. Sivan. 1997. The religious needs and resources of psychiatric inpatients. *The Journal of Nervous and Mental Disease* 185: 320–26. [CrossRef]
- Glas, Gerrit. 2003. Anxiety-Animal Reactions and the Embodiment of Meaning. In *Nature and Narrative—An Introduction to the New Philosophy of Psychiatry*. Edited by B. Fullord, K. Morris, J. Z. Sadler and G. Stanghellini. Oxford: Oxford University Press, pp. 231–49.
- Gonçalves, Juliane P. B., Giancarlo Lucchetti, Paulo R. Menezes, and Homero Vallada. 2015. Religious and spiritual interventions in mental health care: A systematic review and meta-analysis of randomized controlled clinical trials. *Psychological Medicine* 45: 2937–49. [CrossRef] [PubMed]

- Handley, Margaret A., Anuradha Gorukanti, and Adithya Cattamanchi. 2016. Strategies for implementing implementation science: A methodological overview. *Emergency Medicine Journal: EMJ* 33: 660–64. [\[CrossRef\]](#)
- Hare-Duke, Laurie, Ashleigh Charles, Mike Slade, Stefan Rennick-Egglestone, Ada Dys, and Daan Bijdevaate. 2023. Systematic review and citation content analysis of the CHIME framework for mental health recovery processes: Recommendations for developing influential conceptual frameworks. *Journal of Recovery in Mental Health* 6: 38–44. [\[CrossRef\]](#) [\[PubMed\]](#)
- Heinrich, Liesl M., and Eleonora Gullone. 2006. The clinical significance of loneliness: A literature review. *Clinical Psychology Review* 26: 695–718.
- Hem, Marit H., Elisabeth Gjerberg, Tonje L. Husum, and Reidar Pedersen. 2018. Ethical challenges when using coercion in mental healthcare: A systematic literature review. *Nursing Ethics* 25: 92–110. [\[CrossRef\]](#) [\[PubMed\]](#)
- Huber, Machteld, Marja van Vliet, Michele Giezenberg, Bjorn Winkens, Yvonne F. Heerkens, Pieter C. Dagnelie, and J. Anré Knottnerus. 2016. Towards a 'patient-centred' operationalisation of the new dynamic concept of health: A mixed methods study. *BMJ Open* 6: e010091. [\[CrossRef\]](#) [\[PubMed\]](#)
- Kaufman, Caroline C., David H. Rosmarin, and Hilary Connery. 2022. Integrating Spirituality in Group Psychotherapy with First Responders: Addressing Trauma and Substance Misuse. *Religions* 13: 1132. [\[CrossRef\]](#)
- Koenig, Harold G. 2009. Research on Religion, Spirituality, and Mental Health: A Review. *The Canadian Journal of Psychiatry* 54: 283–91. [\[CrossRef\]](#) [\[PubMed\]](#)
- Koenig, Harold G., Michelle Pearce, Bruce Nelson, Sally Shaw, Clive Robins, Noha Daher, Harvey Jay Cohen, and Michael B. King. 2016. Effects of religious vs. standard cognitive behavioral therapy on therapeutic alliance: A randomized clinical trial. *Psychotherapy Research: Journal of the Society for Psychotherapy Research* 26: 365–76. [\[CrossRef\]](#) [\[PubMed\]](#)
- Kruijthoff, Dick J. 2023. Healing after Prayer, an Interdisciplinary Case Study. Ph.D. thesis, Research and Graduation Internal, Vrije Universiteit Amsterdam, Amsterdam, The Netherlands. [\[CrossRef\]](#)
- La Cour, Peter, and Niels C. Hvidt. 2010. Research on meaning-making and health in secular society: Secular, spiritual and religious existential orientations. *Social Science & Medicine* (1982) 71: 1292–99. [\[CrossRef\]](#)
- Lucchetti, Giancarlo, Rodrigo M. Bassi, and Alessandra L. Lucchetti. 2013. Taking spiritual history in clinical practice: A systematic review of instruments. *Explore* 9: 159–70. [\[CrossRef\]](#) [\[PubMed\]](#)
- Lukoff, David, Francis Lu, and Robert Turner. 1992. Toward a more culturally sensitive DSM-IV. Psychoreligious and psychospiritual problems. *The Journal of Nervous and Mental Disease* 180: 673–82. [\[CrossRef\]](#) [\[PubMed\]](#)
- Moreira-Almeida, Alexander, Aydesha Sharma, Bernard Janse van Rensburg, Peter J. Verhagen, and Cristopher C. H. Cook. 2016. WPA Position Statement on Spirituality and Religion in Psychiatry. *World Psychiatry* 15: 87–88. [\[CrossRef\]](#) [\[PubMed\]](#)
- Paas, Stefan. 2012. Religious Consciousness in a Post-Christian Culture: J.H. Bavinck's Religious Consciousness and Christian Faith (1949), Sixty Years Later. *Journal of Reformed Theology* 6: 35–55. [\[CrossRef\]](#)
- Pargament, Kenneth I., and James W. Lomax. 2013. Understanding and addressing religion among people with mental illness. *World Psychiatry* 12: 26–32. [\[CrossRef\]](#) [\[PubMed\]](#)
- Pargament, Kenneth I., Harold G. Koenig, and Lilian M. Perez. 2000. The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology* 56: 519–43. [\[CrossRef\]](#)
- Park, Crystal L. 2005. Religion as a Meaning-Making Framework in Coping with Life Stress. *Journal of Social Issues* 61: 707–29. [\[CrossRef\]](#)
- Poole, Rob. 2020. The sacred versus the secular in UK psychiatry. *BJPsych Advances* 26: 285. [\[CrossRef\]](#)
- Poole, Rob, and Robert Higgs. 2011. Spirituality and the threat to therapeutic boundaries in psychiatric practice. *Mental Health Religion & Culture* 14: 19–29. [\[CrossRef\]](#)
- Rosmarin, David H., Sarah Salcone, David G. Harper, and Brent Forester. 2021. Predictors of Patients' Responses to Spiritual Psychotherapy for Inpatient, Residential, and Intensive Treatment (SPIRIT). *Psychiatric Services* 72: 507–13. [\[CrossRef\]](#)
- Rosmarin, David H., Sarah Salcone, David Harper, and Brent P. Forester. 2019. Spiritual Psychotherapy for Inpatient, Residential, and Intensive Treatment. *American Journal of Psychotherapy* 72: 75–83. [\[CrossRef\]](#)
- Santiago, Pia N., and Terry L. Gall. 2016. Acceptance and Commitment Therapy as a Spiritually Integrated Psychotherapy. *Counseling and Values* 61: 239–54. [\[CrossRef\]](#)
- Schaap-Jonker, Hanneke. 2022. How Clinical Psychology of Religion Can Support Mental Health: An Ecological–Existential View, Illustrated by the Case of Shame. *Religions* 13: 1009. [\[CrossRef\]](#)
- Theobald, Sally, Neal Brandes, Margaret Gyapong, Sameh El-Saharty, Enola Proctor, Theresa Diaz, Samuel Wanji, Soraya Elloker, Joanna Raven, Helen Elsey, and et al. 2018. Implementation research: New imperatives and opportunities in global health. *The Lancet* 392: 2214–28. [\[CrossRef\]](#) [\[PubMed\]](#)
- Thrash, Todd M., and Andrew J. Elliot. 2003. Inspiration as a psychological construct. *Journal of Personality and Social Psychology* 84: 871–89. [\[CrossRef\]](#) [\[PubMed\]](#)
- van Bruggen, Vincent, Joël Vos, Gerben Westerhof, Ernst Bohlmeijer, and Gerrit Glas. 2015. Systematic review of anxiety instruments. *Journal of Humanistic Psychology* 55: 173–201. [\[CrossRef\]](#)
- VanderWeele, Tyler J. 2017. Religion and health: A synthesis. *Spirituality and Religion within the Culture of Medicine: From Evidence to Practice* 419: 357–401.

van Nieuw Amerongen-Meeuse, Joke C., Hanneke Schaap-Jonker, Gerlise Westerbroek, Christa Anbeek, and Arjan W. Braam. 2020. Conversations and Beyond: Religious/Spiritual Care Needs Among Clinical Mental Health Patients in the Netherlands. *The Journal of Nervous and Mental Disease* 208: 524–32. [[CrossRef](#)] [[PubMed](#)]

Yalom, Irvin D. 1980. *Existential Psychotherapy*. New York: Basic Books.

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