Reflection: The Personal *Is* Public

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Abstract
In this article, the author from Rochester General Hospital reflects on COVID impact: "Communication has sometimes suffered cold and automated relationship outcomes but there are oases in this dessert." Personal signals in a public world are humanizing artifacts in a new sterile and hypercontrolled virtual reality.

Keywords
COVID-19, chaplain, personal, homeschool

I am old fashioned and have always believed private things should categorically *not* be public. For example, the idea of holding a camera at arm's length only to point it back at myself seems uncouth, if not self-absorbed. I don't imagine anyone cares what I am eating for dinner, and my resistance to this posting-updating neurosis has been a point of pride.

Now it seems like all I do is point the camera back at my Zoom-self: family, school, church, and work all via video. Everything seems upside down. The other day I came to work on the "B" shift, which for me lasts from 12 p.m. to 9 o'clock at night. I'd never known my department had B shifts. But I enjoyed a very normalizing B-shift conversation with a co-worker who revealed how difficult it has been for her to personally monitor her children's learning while maintaining a professional exterior. I was relieved to hear her struggle because I am also attempting to homeschool six children before reporting to work. Another nurse strategically planned her lunch break in order to help facilitate a son's video conference with his physics teacher. I have seen professional people onscreen with dogs and in living rooms and I was pleasantly surprised to see one journalist reporting from her kitchen with dirty dishes in the sink. These personal signals in a public world are important. I am somehow heartened by these little peeks into people's lives, to know they are human too.

Much of society has slipped into a hyper-privatized reality at the hands of i-technology. Now with a threatening virus, we are pushed even deeper into our respective physical bunkers. I even write this behind a mask and face-shield barrier with the hollow reverberation of my own voice. These items protect but they also make it hard to hear and to speak to others outside my little echo chamber. I am thirsty like never before for human contact, even if it means some selfie-

type behavior. For example, I felt this tech-enhanced human connection when I helped a recent COVID patient to see their spouse through video phone. It was precious, deeply personal, and a privilege to bear witness.

Dutch theologian Henri Nouwen might have it right: "...anyone trying to live a spiritual life will soon discover that the most personal is the most universal, the most hidden is the most public, and the most solitary is the most communal. What we live in the most intimate places of our beings is not just for us but for all people" (Nouwen, 1997). I still don't quite believe a person should air their dirty laundry, but something good is happening here. It has to do with our renewed longing for something beyond the sterility of compartmentalized professional personas or hyper-controlled Facebook pages. Seeing the personality quirks, the dishes in the sink, or the cat walking across a keyboard connects us deeply on a human level.

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A Lifetime of Recovery: Spirituality Groups on an Acute Inpatient Psychiatry Unit

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Spirituality groups provide an environment in which persons experiencing acute stages of mental illness can find healing. Focused spiritual care is an important aspect in the recovery model of mental health care, by addressing the needs of the whole person rather than simply treating an illness. Spirituality groups provide a non-judgmental setting in which patients can discover and experience three elements for recovery: acknowledgement, meaning, and coping skills. This article briefly describes a recovery model for psychiatric care and the acute care environment identifying how the three key modular elements are facilitated within the dynamics of a group. Structured experiences and treatments are particularly important during acute stages of mental illness. This model provides a structured intervention detailed for an acute inpatient psychiatric spirituality group.

Keywords: spirituality group, recovery model, inpatient psychiatry, mental health

Spirituality in mental health care is a popular topic in current literature. However, it is much more difficult to find resources about spirituality *groups* for the mentally ill. From 2011 to 2012, I conducted a weekly spirituality group on an acute inpatient psychiatry unit during my chaplain residency at the University of Rochester Medical Center and became passionate about studying the role spiritual care plays during the acute stages of mental illness.

Spirituality groups in an acute care setting provide mental health patients with an opportunity for recovery as a whole person instead of just receiving treatment for their medical diagnoses. Spirituality groups accomplish this by helping individuals experience *acknowledgement*, find *meaning within a non-judgmental community* and develop *coping skills* to endure living with mental illness. Following a brief overview of the recovery model and the acute care environment, I discuss these three elements as they relate to recovery from mental illness. A model for an acute psychiatric inpatient spirituality group is included as the Appendix.

The Recovery Model

During much of the 20th century, the importance of spirituality was often downplayed or discarded as clinically relevant in psychiatric treatment. Freud correlated religion with neurosis and a lack of developmental maturity, making suspect any patient's discussion of spiritual matters (Galanter et al., 2011). This attitude has been influential in the culture of psychiatric care. Other clinicians have disregarded spirituality as "a vague construct that is not amenable to empirically oriented research." (Galanter et al., 2011, p. 87). McGee and Torosian noted "no inpatient psychiatric program to our knowledge has systematically integrated spiritual assessment and intervention into their program in order to promote clinical outcomes." (2006, p. 60).

This attitude has been slowly changing as many mental health institutions have begun to adopt a different model for treatment – a recovery model as opposed to a medical model. In the medical model, mental illness is seen as a set of symptoms that must be removed, and that the best way to do this is through scientific trial and error. In the recovery model, though symptoms are still addressed through medical intervention, health care providers focus on the patient as whole person and his or her potential to live a rehabilitated life (Lukoff, 2007). The emerging

operant question becomes not "can you find a cure for my illness?" which can lead to frustration and despair when the illness persists, but "can I live a satisfying, productive, and stable life *with* mental illness?" Spirituality plays a significant role in this model.

Spirituality as a component of health care has become increasingly recognized in recent years. In 2008, the Joint Commission for the Accreditation of Health Care Organizations expanded its material for performing spiritual assessments and addressing spiritual needs. Questions such as "what does suffering mean to you?" are designed to address not only a patient's physical health but his or her entire outlook on life (Joint Commission, "Provision of Care, Treatment and Services (CAMH/Hospitals)," 2013).

In discussing recovery, it is important to distinguish spirituality from religion. Religion is central to a distinct community of faith and its system of beliefs and practices. Harold Koenig defines spirituality as the individual's ability to find meaning amidst life's ultimate questions (2005). All persons have a spiritual component, just as they have mental, physical and emotional components. Persons are spiritual irrespective of concepts of God, systems of belief, or lack of belief in the transcendent. Spiritual pursuits establish a "congruency between values and actions" (University of California, Riverside, "Seven Dimensions of Wellness," 2012). This congruency is a healthy goal for everyone. Spiritual components relate to many dimensions of life including such elements as courage, hope, and fear. For persons suffering with mental illness, getting in touch with one's spirituality can become a major component contributing to lifetime recovery.

Acute Care Defined

An acute care inpatient psychiatric unit is a unique and high-intensity environment. Patients admitted to an acute unit possess elevated symptoms of an active psychiatric disorder that is interfering with psychological, social, and/or occupational functioning (Koenig, 2005). These patients present an immediate danger to themselves or others or are presently unable to take care of themselves due to an elevated state of mental illness (Beth Israel Deaconess Medical Center, "Psychiatry Inpatient Unit," 2013). Patients who suffer from a myriad of disorders such as psychosis, schizophrenia, depression, and mania, often co-exist for days or weeks on an acute unit. The primary goal of such acute care units is to help patients recover from the acute stage of illness so they can return to baseline a possibly healthier functioning and quality of life that may include consistent outpatient mental health care.

On the MICA (Mental Illness/Chemical Addiction) unit at the University of Rochester Medical Center, the patients' days are largely unstructured. Patients are free to stay in their rooms or move about the unit unless they are in isolation. There is a small lounge area, with a television and board games, as well as a locked solarium that is opened for group sessions. Nurses administer medication to patients and circulate to each room for periodic safety rounds. The clinical staff observes patients' behaviors throughout the day to assess their progress toward recovery; face to face clinical time is limited. During my residency, one hospital psychiatrist who had met with the unit's chaplain team several times stated that his patient load allowed him to spend an average of 17 minutes with each patient per week.

Medical and clinical staff on an acute unit may run daily or weekly groups focused on specific themes such as coping skills, exercise or art to give patients an opportunity for healthy interaction and activity. These groups are optional, and patient participation is the health care team's daily assessment. The spirituality group I facilitated was one such group. However, the bulk of time during the day belongs to the patient. The primary foci of care on the acute unit are safety and stabilization and not therapy or rehabilitation. The integration of a spirituality group on this unit becomes important because it can help prepare patients for continued recovery once they leave the acute unit.

Dr. Nancy Kehoe, who led psychiatric spirituality groups at Harvard Medical School for two decades, noted that patients need to experience "respect and interest" from peers and caregivers in order to begin to see themselves differently (2007, p. 648). In any mental health care setting, patients need to be acknowledged and not only when they are "acting out" or when they receive their medicine.

Many persons with mental illness are or feel alienated. They may have become abandoned by both friends and family. Many have adopted a "sick role," having spent months or years in and out of psychiatric treatment. Thus, they may no longer feel like "a person whose meaning, worth and purpose are larger than and more essential than a person with an illness" (Bussema & Bussema, 2007, p. 304). They may feel that others define them by their illness, and they may begin to see themselves this way as well.

In a spirituality group, patients are encouraged to share their thoughts about the group's theme for the day or about their in-the-moment experiences. If the theme is hope, one patient may share that she has lost all hope. Another patient may respond that he feels the same. The group leader can affirm these responses and ask the patients to share more. As they do so, the patients often find common ground. They are not judged or corrected, and may come to recognize that they are not alone.

I choose to use the words "group leader" instead of "group facilitator" throughout this article even though the role often encompasses both components. In acute care, structure is important; it provides a safe, organized space in which patients know what to expect. A leader provides and holds to this structure as the group progresses while giving patients freedom to express themselves within it. Leaders do not draw attention to themselves or seek to take on a teaching role. The Appendix proposes two group structure models in detail.

In the spirituality group, patients are acknowledged for the positive aspects that make them unique. One spirituality group theme I led was focused on names. We read a few short narratives about the significance of names. Then I asked everyone to share his or her first name and something about it — where it came from, why they liked it or disliked it, or what it meant to them. Everyone was able to share and listen to one another. Activities like this make the patients' humanity, not their sickness, the emphasis of the group.

Robert Kidd, who led a narrative-based spirituality group for inpatients and outpatients at the Texas Medical Center, wrote about the effect of his group:

> Patients report that the Spirituality Group is helpful for them because they feel some competence there. They are not directly taught anything...it is an occasion in which staff and patients participate in a discussion on a more even footing as opposed to the more common helper/helpee paradigm. (2001, p. 363)

Kidd used sacred narratives from many cultural traditions as a means to "give shape" to the emotions and longings that are often difficult for acute patients to share. In the group, patients found acknowledgement for the meaning they took from the narratives. They were affirmed by the leader and peers as they shared how they found the story connected with their own experience. Patients' unique experiences are viewed as strengths, something that is quite important for people who are used to being classified by their weaknesses.

Patients who have embraced the "sick role" often believe that they can no longer help themselves. It can be powerful, especially in a group setting, when someone acknowledges the positive resources they *do* possess that can aid them in recovery. When friends and family are no longer constants in patients' lives, there may be no one around to point out anything positive. Thus patients are left with their own self-deprecating thoughts. In a spirituality group, leaders can "ask participants to describe previous experiences when they felt spiritually whole or when they were able to overcome challenges" (Popovsky, 2007, p. 125). With encouragement, most

people can think of such a time. The leader helps make it clear that these experiences are still a part of the person and can continue to aid in recovery.

The leader helps patients find acknowledgement, listening attentively and looking for opportunities to make connections. Jo Hirschmann found many such opportunities during the spirituality group she led for acute care psychiatric patients at the Westchester Medical Center. When she witnessed one patient addressing another with a compliment or advice, she asked the recipient how it felt to receive these words (Hirschmann, 2011). The recipient then has the opportunity to share an unfettered response and achieve validation for doing so. Popovsky pointed out the importance of a leader linking "the observations and insights of one group member to those which another has already offered in an effort to help participants feel heard, understood, and validated" (2007, p. 123).

Positive acknowledgement from one person to another is a simple yet intentional act. Many persons who have lived with mental illness for a period of time may feel that they are only recognized by what makes them ill and socially unacceptable. "By asking a question of another person and listening carefully to the response, we communicate that we see the person as worthy and valuable" (Hirschmann, 2011, p. 971).

Those living with chronic mental illness are often trapped inside their perceptions of themselves and the world around them. Hirschmann observed "psychiatric inpatients are cut off from the rituals that ordinarily frame their days, weeks and years" (2011, p. 973). When someone reaches out to acknowledge a patient's humanity and recognize their value apart from sickness, it can become a catalyst for patients to see themselves differently and apart from the shadow of societal expectations.

Acknowledgment can also be a powerful catalyst when it is used to identify something destructive. Nancy Kehoe related a story of a patient who was unable to use her own spiritual resources during her times of greatest mental anguish. Her clinicians' only reference to her spirituality was when the patient was into her "devil thing" (Kehoe, 2007, p. 647). In Kehoe's spirituality group, the patient found the capacity to open-up about her beliefs and later received personal attention from a psychology intern who helped her integrate her beliefs into her recovery when she needed it most. Kehoe reflected that the patient "had spiritual resources that gave her comfort and strength, as well as beliefs about being evil that caused her enormous distress" (Kehoe, 2007, p. 648). The patient's innate healthy resources as well as her harmful beliefs about herself were given voice in the spirituality group, allowing her to integrate the one and find freedom to eventually begin to dismiss the other.

Finding Meaning in Community

Persons often find it hard if not impossible to embark on a journey of lifelong recovery without simultaneously achieving some sense of personal meaning. Even some miracle drugs that might erase symptoms of mental illness do not address the ultimate questions of life: What am I here for? Do I matter? Am I worthy of love?

In *The Rebirth of the Clinic*, Daniel Sulmasy concluded "an atheist must search for personal meaning and value in light of his or her rejection of the possibility of a transcendent source of personal meaning and value" (2006, p. 14). Regardless of religious affiliation, culture, or worldview, it is important and healthy for people possess some concept that conveys meaning to their existence.

Harold Koenig identified a fault in the scientific approach to mental illness in that it supplies no meaning. He draws from Viktor Frankl's seminal work *Man's Search For Meaning*:

> The scientific worldview works wonderfully for...those blessed with good health, material resources, and interesting occupations. For those who are experiencing severe stress, multiple losses, socioeconomic deprivation, or prolonged pain or suffering, however, it does not work so well. The reason is because the scientific worldview is completely devoid of meaning, and it is *meaning* that enables those who suffer to survive (Koenig, 2006, p. 135).

Spirituality groups play a significant role in providing a healthy atmosphere for patients to explore meaning. While everyone can pursue some aspects of spirituality alone, a healthy and developing spirituality is more readily pursued in community. This is especially true for those suffering with acute mental illness, because, left alone, their own minds can be prone to distorting reality. Even normal spiritual practices like prayer, meditation and scripture reading, when done alone, can provide little or no comfort to the acutely mentally ill. Patients need the opportunity to build healthy social connections in an environment conducive to respect and true acceptance (Popovsky, 2007).

Koenig questioned the effects of clinical mental health treatment if the worldview of the caregiver is radically different than that of the patient. In a spirituality group, patients experience the community of peers and caregivers where each person's insights are welcomed and joined. Patients may find some aspects of their worldview challenged, but judgment is not tolerated. This is a key difference for a person who is used to being defined as "wrong" or "different" by those around them.

In Kidd's spirituality group, patients "are called on to move beyond preoccupation with their own illnesses and into enhanced community with others" (2001, p. 354). An individual in need is brought into a community of others in need. Sacred stories, like those used in Kidd's group, bring hurting people together because each person finds his or her place in the narrative; the stories speak to them both individually and collectively.

On the acute care unit, I witnessed several patients begin to engage in a positive manner with their peers following encounters in the spirituality group. Our group always ended with a musical meditation during which I encouraged patients to draw sketches or write thoughts. One patient who drew beautiful sketches during the musical meditation began creating more artwork in her room. I began to see her artwork on other patients' doors as she drew pictures and gave them away as gifts.

Another patient painted scenes on paper plates. She only had one hanging in her room, and I asked her where all the others were. She couldn't believe I thought she would keep them all; she had given them away! Her clinical diagnosis was psychosis, and some days she was so labile she was unable to interact with others without being overbearing. Nonetheless, her humanity was able to shine through her art. Hirschmann pointed out two basic human needs that can be fulfilled through spirituality groups: the "need to be the focus of anothers' attention" and the "pleasure that comes from answering questions directed to us alone" (2011, p. 973). Many psychiatric patients are used to being the focus of another's attention due to erratic or withdrawn behavior. A spirituality group can enable the participants to receive attention in ways that enhance recovery.

The leader can build community in the group by asking open-ended questions and giving each patient an opportunity to answer. The leader asks the question and allows each patient to answer without feeling judged, belittled, or cut off. Popovsky listed some effective open-ended questions, some of which are:

> What does it take to forgive someone else?
> What gives life meaning and value?
> Can you describe a time when you felt spiritually whole?
> Can you have doubts or be angry at God and still hold onto spirituality? (2007, p. 123)

Hirschmann used questions to bring up topics for patients to find common ground:

> What makes you sad?
> What is something you are good at? (2011, p. 966)

The group leader's responsibility is to set clear boundaries that help patients remain in the here-and-now in order to accomplish the work of the group (Popovsky, 2007). In the acute psychiatric setting, a patient's speech can become accelerated or intrusive. Leaders delineate boundaries at the group's onset, but how they enforce them at moments of conflict becomes

critical. Simple interventions to redirect are often welcomed by patients expressing manic or psychotic symptoms (Popovsky, 2007).

Popovsky made another observation that I, too, witnessed in the acute care unit. Spirituality group "often attracts people in depressed states where verbal participation is limited and people in manic states where self-restraint is difficult" (2007). With such a mixture, one might think the group would descend into chaos and become unproductive.

In the general unit milieu, verbose patients often dominate the space while depressed patients hibernate. I remember leading groups where some patients would sit with their heads faced to the floor when others would begin talking non-stop the moment they entered the room. However, by its very nature, the spirituality group seems to stabilize such behaviors and to draw individuals out of themselves. . In group, I worked to facilitate a calm, structured environment where everyone felt free to share or participate silently.

Leader confidence seems key. If a patient becomes accusatory or antagonistic, the leader simply redirects them or invites others to share a response to what is happening (Popovsky, 2007). Several authors (Kehoe, Popovsky) noted that they have never had to ask someone to leave group, though some patients will choose to leave on their own. Patients who are used to negative attention find acceptance and challenge while still being allowed to remain a part of the group.

Withdrawn patients find that even though their opinions are invited, they are not under any expectations to share. Often, this kind of open group environment brings withdrawn members slowly out of isolation as they sense their genuine value to those around them. Whether they speak or not, simply attending the group is an opportunity for the leader and other group members to affirm their courageous participation.

Coping Skills

Effective psychiatric treatment "must promote patients' hope for their future well-being" (Galanter et al., 2011, p. 81). A lifetime of practical recovery is much more valuable than a temporary cessation of symptoms. If spirituality groups are to be a consistent part of the recovery culture of psychiatric treatment, they must provide something of value for patients to take with them on the journey of recovery.

The 12-step recovery model is based on the idea that people respond best to someone who can understand what they are going through (*Alcoholics Anonymous*, 2001). A physician or therapist may have expertise, but some patients find it difficult to transcend the clinical barrier. In spirituality group, a level of trust can develop between patients who share similar experiences. The leader can moderate peer to peer communication, encouraging positive reinforcement and moderating comments that may be harmful or judgmental.

Patients may share spiritual practices such as "creative projects, breathing or meditative techniques, and religious rituals that provide comfort, courage or hope" (Popovsky, 2007, p. 126). Others may be willing to give these practices a try. Positive reinforcement from peers can help a patient begin to work through issues that are binding, such as judgmental images of God conjured up by a domineering parent.

Conflict resolution is a skill that is modeled in the group process. The leader does not sidestep conflict, but can skillfully guide and allow it exist to help patients learn that "emotions such as anger, doubt and fear...need not be avoided or minimized" (Popovsky, 2007, p. 127).

One way a leader can channel conflict is that instead of directly opposing or redirecting an antagonistic patient, the leader asks other group members to express reactions to what is happening (Popovsky, 2007). In this way the conflict does not threaten the group, but simply offers another opportunity for the group to work together toward coping with reality. Whether the antagonistic patient responds positively or negatively to the reaction of his or her peers, all group members can learn through the experience and express their emotions.

As a novice group leader, I was initially uncomfortable with conflict, afraid that an overbearing or angry patient would derail the group. Over time, I found that conflict can help patients learn to cope just as well as a peaceful exercise such as a musical mediation.

Christopher O'Rourke wrote about one patient who, though antagonistic and resistant to the group at first, found that he was eventually able to talk about things freely that he wasn't able to disclose with family members for fear of judgment or reprisal. Though he lashed out at others initially, he was allowed to remain in the group. Eventually he experienced the feeling of actually being heard and realized that no one was passing judgment or accusing him. O'Rourke refers to this feature as "the power of the group to tolerate, contain and heal grandiose, narcissistic individuals" (1997, p. 188). In group, a person learns how to experience attention and acceptance without playing the victim or the sick role.

Perhaps the most important coping skill for patients struggling with mental illness is practicing contentment. A common response I heard from acute patients on the unit, especially if they saw their hospital admission go on for weeks, was "I just want to get out of here." They saw the hospital as constrictive and oppressive. I used these responses as an opportunity for the group to discuss the reality that often our circumstances are out of our control, with questions such as "Is it possible to find peace in an environment that is uncomfortable? How?" Such questioning always generated thoughtful ideas and experiences.

Contentment is a way of being and participating in the here-and-now (Hirschmann, 2011). The leader in a spirituality group learns to find creative ways to emphasize this kind of mindfulness. If one can accept the present moment, and live in it, they may learn to live outside the shadow of the past or fear of the future. Many times, persons with mental illness define their existence based on past events or failures or are in such fear of what might happen to them next that they are in a constant state of anxiety. They see their powerlessness over the illness, the cycles and alienation, and cannot see themselves any other way. In the acute stage, they are often unable to achieve such awareness if it is explained to them directly. However, if they see it modeled by the leader and others in the group through narratives or discussions of spiritual themes, they can find freedom by participating in an environment where they are accepted for who they are *right now.*

Research shows that regardless of their religious background, many mental health patients regard prayer as their primary coping strategy. Tepper et al. surveyed over 400 psychiatric patients and found that "a majority of participants devoted as much as half of their total coping time to religious practices, with prayer being the most frequent activity" (2001, p. 660). Tepper et al.'s article references many other studies that also found prayer a primary coping mechanism.

Prayers of request for healing often lead to disillusionment and frustration when healing doesn't come. In spirituality group, patients can discuss the theme of prayer and what it means to them as a way of getting outside themselves. The 12-step model hinges on finding a higher power of your own understanding, but one that is outside yourself (*Alcoholics Anonymous,* 2001). This model is also applicable to recovery from mental illness. The god of a certain religion is not right or wrong; in spirituality group it is not necessary to ascribe belief to any certain deity. If a person has trouble accepting the notion of God, he is free to reject it. One of the goals of a spirituality group is simply to help patients find that they are a part of something much bigger than the oppression or obsession of their own minds.

Spirituality Group Model

The spiritual group model described in this paper is aimed at acute psychiatric care, and is therefore very structured (see Appendix). Other spirituality group models are more free-flowing, allowing patients to take the group where they would like. The spirituality groups I led typically lasted from 30-45 minutes. In creating this model, I drew elements from a spirituality group outline created by Suzanne Shady, chaplain with Unity Health Systems in Rochester NY. I also

drew elements from my Clinical Pastoral Education residency training at the University of Rochester Medical Center in Rochester NY and from the 12-step recovery model.

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Model for an Acute Inpatient Psychiatric Group

Before group begins	Leader greets each patient by name upon entrance, learning name if the patient is new to group. Allows patients to choose their seats around a large table.
Opening	Leader introduces self and welcomes all, explaining 1) the purpose of the group, 2) the differences between spirituality and religion, 3) that the setting is a non-judgmental, that everyone's beliefs will be respected, and that all are free to share or just participate silently.
Outline of group	Leader states what will happen in the group. It isa good idea is to have the outline written on a white board beforehand for all to see. Doing so helps establish structure and comfort about what is coming next. An outline might look like one of the following:

> A. Introductions
> Centering exercise
> Story reading – "What's in a name?"
> Discussion of story
> Musical meditation
> Closing moments of silence/prayer

> B. Introductions
> Centering exercise
> Question: "What does *unconditional love* mean to you?"
> Discussion/interaction around question
> "Stones of hope" practical exercise
> Closing moments of silence/prayer

Introductions	Leader invites all to share their first names and one word to describe how they are feeling in the present moment. Leader models this by going first.
Centering exercise	Leader invites all to participate in a simple centering exercise of his/her choice, to focus on being in the here-and-now. "Seven breaths," etc.
Story/Question	Taking turns, group members read through a story together out loud or listen to leader pose a question for discussion.
Discussion	Group discusses story or begins to answer the question. Members take turns sharing their views. If someone interrupts the speaker, the leader gently redirects the person to wait his/her turn. Members can share what they believe but should not tell others what to believe. Leader draws connections between member comments and affirms those who shared their comments. Leader facilitates discussion but allows discussion to work itself and limits his/her own commentary (*Sexaholics Anonymous*, 1989).
Practical exercise	1) Musical meditation: If the leader (or another staff member) can play an instrument, a live musical meditation works well here. Hand out paper and pens. Play 5-7 minutes of meditative music and encourage group members to write their thoughts, a poem, or draw what comes to mind. It could be something that relates to the discussion or something they are dealing with personally, or a memory.
	2) "Stones of hope": An exercise like this can also be powerful. Set a glass jar in the middle of the table and surround it with stones. Invite

group members, as they feel ready, to take a stone and put it in the jar. As they put it in the jar they should share something they are hoping for – it could be for themselves or for someone else. Or the leader could invite them to share something related to the day's discussion topic as they put the stone in the jar.

Closing

Leader invites all to observe a moment of silence, and to pray silently if they wish to do so. I have also read the serenity prayer, asking those to pray it out loud if they wish, since this is a prayer that is universally accepted in the rooms of recovery and is interfaith.

N.B. The leader also informs members that a chaplain is available to speak one-on-one with them after group or at another time. Spirituality group can be a way to help patients feel comfortable in asking for help from a chaplain. Many people are unsure of the role of a chaplain or what they are willing to do, and, by the chaplain offering, the patient is given a choice to ask for more help if he or she wishes.