Tending to Spiritual Health and Mental Health

An Introduction to a Parish-Based Spiritual Therapeutic Community

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Combining his role as deacon and clinical psychiatrist, the author reports on the development of a successful approach to group interaction that dovetails pastoral and clinical care in a parochial setting.

“As the hind longs for the running waters so my soul longs for you, Oh God!” (Ps 42:1).

When modern medicine promoted the divorce of mind and spirit, mental health patients and professionals became separated by a “client”-“expert” split. For the past few decades, modern psychiatry has delineated roles for patients and practitioners. It may well be, indeed, that the often secret suffering of patients and the providers’ persistent exposure and immersion in that suffering brings both groups closer in a shared “holy longing” for a connection with transcendence.

In this article I will describe the spontaneous generation of joint ministering of patients and providers of mental health in an urban parish and the way this mutual tending has unfolded into an experience of spiritual healing and development for both groups. Specific information about the initial steps of this “Parish-Based Spiritual Therapeutic Community” (hereafter, PBSTC) will illustrate the natural history of this ministry. The psychosocial framework and conceptual...

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rooting of the PBSTC could fit the psychiatric model of the therapeutic community. At the same time, the PBSTC has resulted in an opportunity for spiritual transformation.

**History of Saint Paul’s Parish-Based Spiritual Therapeutic Community: “There’s Really Something Going on Here”**

In September 2002, a parish-based spiritual therapeutic community was established under the auspices of the diocese of Richmond at Saint Paul’s Catholic Church in Richmond, Virginia. This group has been mending the modern divorce of mental health care and the care of the soul while bringing together providers and consumers in a refreshed venue. The PBSTC of St. Paul’s parish is an outreach ecumenical ministry for the community at large. The PBSTC meets weekly in a structured setting that incorporates elements of a traditional group therapy session, a spiritually directed group meeting, and a prayer group in an atmosphere akin to self-help gatherings, such as Alcoholics Anonymous. The main topic is the way we live our lives, where our energy comes from, and what keeps us together, rather than focusing on what is wrong with the way we are and our differences as professionals and consumers. The atmosphere is naturally relaxed and friendly.

This experience started in 2002 when I left the so-called “Mental Health Industry” in which I had worked for three decades to enter the practice of pastoral psychiatry and joined the staff of Saint Paul’s Catholic Church in Richmond, Virginia, as pastoral associate. During the previous five years, I was a deacon at the parish and a diocesan consultant in pastoral psychiatry while practicing full-time family psychiatry in a multi-disciplinary group. In 2002, I started to focus on projects that could lead to the design of a spiritual model and expand the scope of this nascent ministry.

Some of my former patients were aware of my new affiliation with Saint Paul’s parish. They wanted to continue our relationship and we agreed to meet in a distinctly different setting—after 8:00 a.m. Mass on Wednesdays. This new format evolved as we proceeded with the meetings. Eventually six patients regularly attended meetings after Mass. We met in the commons of the church and talked for twenty minutes. If the patients chose to do so, I would see them individually after the group meeting. Within a few weeks it became clear that the interaction was different than what I had experienced in my previous clinical practice. The patients began to talk among themselves while waiting to see me. The church secretary spontaneously offered them coffee. They were remarkably relaxed and so was I. Soon I joined their conversations around issues of the church, recollections of past treatments, histories of their families, and the role of God in their lives.
About two months later in a hospital parking lot, Helen, a friend who is a psychologist, asked what I had been doing. After I explained that I had started a spiritually based practice, Helen responded: “That’s exactly what I am looking for. I want to put together ‘faith’ and ‘therapy’ in a safe environment. Can I come?” Of course, I said, yes. Helen attended and invited three other patients. Now the meetings had been moved to the parlor, a new addition to the church. I had furnished the room with fixtures from my former office. At the meetings, we brewed and sipped coffee and talked about our relationship with God. Halfway through the meeting I would excuse myself and step into my office while Helen continued meeting with the group. One by one, those who wanted personal individual time with me came into my office. When we finished, depending on the lateness of the hour, I would rejoin the group. Our pastor had been observing the comings and goings of the Wednesday morning meeting participants. After a few months, he commented to me “There’s really something going on here” and offered the Religious Education building for our meetings. The PBSTC has been functioning now for three years.

**Melding into a Model**

Within the mental health community providers have long recognized the power of groups. As a group, the PBSTC provides a vehicle for the expression of human nature. The clinical providers became aware of a powerful dynamic as the patients and therapists met through PBSTC weekly. We came to describe this dynamic as an enduring sense of unconditional regard and acceptance shared among peers that we clinicians recognized as a derivation of the classic therapeutic community model (Ganzarain, 2003).

The roots of the therapeutic community model date to the mid 1940s when a bulletin of the Menninger Clinic published an article by Tom Main introducing the model’s concept. Dr. Main wrote: “The Northfield Experiment is an attempt to use the hospital not as an organization run by doctors in the interests of their own greater technical efficiency but as a community with the immediate aim of full participation of all its members in its daily life and the eventual aim of the resocialization of the neurotic individual for life in ordinary society” (Main, 67). The model was deployed in England at the Tavistock Clinic and the Cassel Hospital to meet the needs of returning World War II veterans and the civilian population. The use of the model reflected an effort to respond to the needs of people who were dealing with the trauma of war and its aftereffects and who found little comfort from “outmoded religious rituals” (Pines, 2).

Maxwell Jones is often credited with further developing the model in the 1950s. In 1953, Jones, a former psychiatrist of the British army, published his seminal book *The Therapeutic Community: a New Treatment Method in Psychiatry* in...
which he described the process of inviting hospital staff into the meetings with the patients each morning (Jones, 1953). In doing this, “he reordered the hospital culture and flattened the pyramid of authority to promote productive interaction between patients, nurses, staff and doctors” (Bloom, 73).

After participating in the PBSTC and reflecting on its evolving dynamics, the clinician members were drawn back to the work of the late psychiatrist Wilfred R. Bion. We came to appreciate anew his teaching that the group itself does not create the expressions, but facilitates them. Three of the providers had known Bion’s work through training at the Menninger Clinic many years earlier. Bion applied psychoanalytic theory to group and clinical practice with an innovative and uncompromising style that generated many followers. His concept of the “group as a unit with a group mentality” and his description of “the basic assumption of groups” provided for further research and enhanced the psychoanalytic understanding and practice of group psychotherapy (Grinberg, 3–21). Much to our surprise we also learned that Bion had inspired Jones’ initial work with groups at the Tavistock in London after World War II (Kennard, 1998, 13). Later the concept of “milieu therapy” was coined to understand and develop the new model of the therapeutic community—the creation of an environment conducive to the reintegration of the person to a higher level of functioning.

These two modalities—the therapeutic community and milieu therapy—have become an integral part of modern in-patient psychiatric programs worldwide. In the United States the therapeutic community model had been applied most frequently in the field of substance abuse treatment until the work of George de Leon at the Center for Therapeutic Community Research in New York City. His concept of “the community as method” and his book of the same title were published in 1997. De Leon extends the therapeutic community model to “special populations and special settings,” which include systems other than substance abuse treatment, such as criminal justice, hospitals, mental health, childcare and education. “Community as Method” refers to the “purposive use of the peer communities to facilitate social change in individuals” (De Leon, 5). The same author later noted:

The cross-fertilization of personnel and methods from the traditional therapeutic community model, mental health services and human services portends the evolution of a new therapeutic community model: a general treatment model that can be applicable to a broad range of populations for whom affiliation with

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a self-help community is the foundation for effecting the process of individual change (Gabbard, 902).

Our heterogeneous group of individuals with interdependent roles, sharing a goal of spiritual growth, reflects an ongoing evolution of this prediction.

**Implicit and Explicit Tenets**

The main concern of the PBSTC is its members’ well-being. The PBSTC is only active during the time of the meetings and it does not offer professional services. Members sign an agreement recognizing the nature of the PBSTC. Opinions of members represent their own personal points of view and are confined to the setting of the meetings.

The basic value implicit in the functioning of the PBSTC is safety. Members must feel certain that their personal boundaries will not be violated emotionally or physically. They are expected to keep all matters within the group confidential and not to contact each other outside of the group without explicit agreement of the group. After a few meetings, the participants discussed the following requirements for participation:

• A desire to be forthcoming;
• A sense of good will, respect, and tolerance for others;
• A commitment to participate regularly;
• A pledge of confidentiality; this pledge requires members to abstain from talking about people or events addressed in the meetings to non-group members, and to avoid conversations among members outside the meetings.
• A commitment to define explicitly to the group a specific personal goal to be attained through membership in the PBSTC; this may be done in writing to facilitate follow-up and accountability.
• A sincere effort to address personal goals and expectations about the PBSTC itself and to review these goals and expectations periodically.

**PBSTC Parameters and Procedures**

The PBSTC functions as an ambulatory, open ecumenical group. The pastoral psychiatrist and the psychologist are the informal leaders. Sometimes other member-therapists take a prominent role. After a brief prayer and meditation, members introduce themselves and bring newcomers up to date with the
history of the group and recent developments. Any group member begins talking in a way that is similar to traditional group psychotherapy.

All members are on a first-name basis with each other. There are no specific requirements for attendance, so it fluctuates every week. The meetings do not have pre-set agendas. Dialogue flows easily with minimal facilitation from the clinicians and members do not interrogate or judge each other. Tolerance for silence and listening are encouraged while leaders steer conversations away from anxious chitchat. The interaction of the members is meant to invite compassion, to promote trust and disclosure, and to foster an atmosphere of tender vigilance in which members stand ready to gently tend to the needs of each other. [The concept of tender vigilance emanates from the writings of Leonid Federov (1879–1935) who envisioned Christian life as reflecting two basic attitudes: vigilance which he described as manly and tenderness which he saw as feminine.]

**Member Information**

Members are adults who are or have been in mental health practice or treatment and are moved to tend to their spiritual needs. Information about and an open invitation to our group are printed in the parish bulletin. Recruitment is mainly by word-of-mouth. For example, participating clinicians invite other mental health professionals who show an interest in the convergence of psychotherapy and religion from the experiential point of view.

Approximately twelve to fifteen people form one group. With consistent attendance of sixteen or more members, a second group can branch out. If not, a group with fifteen fluctuating members can function adequately. There are more female members than male members. The age of members fluctuates from middle twenties to early seventies. About two-fifths of the membership are clinicians.

**Clinical Considerations**

The coming together of several patients and therapists initially and naturally creates tension as people enter a new situation with yet unknown parameters. In our case, I am usually the host and have the dual role of physician and clergy. When we start the meetings we have a moment of quiet prayer and reflection. After this, the tension dissipates; the group is relaxed and ready to "work." With psychiatric illness as a common thread among members, diagnosis and treatment are an open subject. The members—to different degrees—address their clinical
histories or issues of current mental health concerns. Often, this disclosure occurs at the beginning of their participation in the group. Most members who have been mental health patients are afflicted by chronic, relapsing conditions with significant loss of executive functions, social skills, and working capacity. For example, these conditions include mood disorders, post-traumatic stress disorder, substance abuse disorders, dual diagnosis personality disorders, learning disorders, and attention disorders. None of the regularly attending patients suffers from schizophrenia, dementia, or mental retardation. Most members described their in-patient experiences as unhelpful.

If, during the group, it becomes apparent that a member is suffering acute symptoms specific to his or her disorder or his or her mental status is decom-pensating, the leader or co-leader will refer the member to his or her clinician. Compliance with psychotropic medications, attending medication checks and concurrent psychotherapy, abstaining from non-prescription drugs and alcohol, maintaining general health care and a healthy diet are mutually encouraged among the participants. Psycho-educational tools are explored naturally as members respond to issues that are brought to the group. Members may also receive specific feedback from clinicians about particular issues they bring to the group. This information is intended and understood to be an illustration of alternatives the member may choose to take, rather than a clinician’s prescriptive course of action.

This multidisciplinary team has involved the collaboration of a psychiatrist and deacon, two psychologists, a licensed clinical social worker, a licensed professional counselor, a psychiatric nurse, and a retired nun. A sense of collegial leadership among these professional members guides the group. The leadership is fluid, evolving from the experience of the clinicians’ previous work with each other or in clinical teams. The leaders guide the group through open dialogue.

Undoubtedly, the presence of a seasoned licensed clinician provides reliability for this endeavor and accountability to the church leadership. Clearly this model should not be established without a clinician present and providing guidance throughout its development.
Pastoral Considerations

The goal of our meetings of mental health providers and consumers is to experience and share the “healing power of God’s love” through the process of our interactions. In this communion we are able to bridge our protracted history of spiritual separation.

One of the group members compared the PBSTC experience to the American Indian tradition of rug weaving. In the same way that the rug-maker weaves imperfections to symbolize “the Eye of God”—an opening for the Divine to enter and to transform the owner of the rug—the Holy Spirit joins us to form a community with a “holy longing” for healing and growth.

The suffering of mental illness is overpowering and hope-squelching. Within the PBSTC, psychiatric illness and its suffering is a common bond that brings an unspoken sense of empathy. Members are readily able to mirror each other’s feelings as they share their mental health struggles. Because members have attained different levels of mental wellness, they are able to help others by providing validation, modeling and inspiring hope. When members who are suffering hear and see others who have walked a similarly difficult path and have been able to accept their illness and begin to develop other parts of themselves, they begin to experience hope.

Mystics and poets have described the spiritual phenomenology of their own souls with intense images and similes. It would be pretentious to attempt here a comprehensive description of the spiritual issues addressed in our PBSTC meetings: we can only attempt a general approximation. If we compare the ingredients of the PBSTC to a potter in action, we glimpse the spiritual transformation that takes place in our meetings. The clinicians represent the water and the patients, the clay. The wheel is the group and the potter is the presence of God among us. (Jer 18:1; Matt 18:20).

The group has marked its own spiritual road signs, acknowledging, by the meeting’s end, some discoveries in the contemplative journey. We have come to a fuller experience and understanding of the Communion of Saints in action. In our meetings, the spiritual/religious experience is not a dialogue of silence for the individual. Instead, a connection with God is felt in the presence of the “other,” who mediates God at work through the Holy Spirit. Indeed, we are “temples in whom the Holy Spirit dwells” (Eph 2:22; Eph 3:17; Heb 3:6; 1 Cor 3:16; Rev 21:3; 2 Tim 1:14). We are empowered by the Holy Spirit to share with one another the

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spiritual fruits of “love, joy, peace, patience, kindness, generosity, faithfulness, gentleness and self-control” (Gal 5:22-23).

We share a sense of connection with Christ in the group that professes the mystery of his Incarnation in the People of God by virtue of the power of intercessory prayer which rebuilds the Body of Christ within our community. Prayer becomes the abiding connection that is re-activated for those returning to the group even after some period of time. The participants describe their experience in the PBSTC as a “homecoming.” The encounter of our souls happens in the sacred garden of the Lord where all members are equally graced by the Creator and relate to each other accordingly.

The functioning of our group satisfies a spiritual need in the community at large. The consensus among the participants is that there are no other opportunities for providers and consumers to meet together to incorporate the spiritual dimension in mental health care. Our community also fosters personal bonding in a non-institutional setting.

**Conclusion**

The PBSTC described here represents an experience with a combined group of patients and mental health providers. The characteristics of our PBSTC have been discussed with an emphasis on the interweaving of clinical and spiritual factors in the context of a common faith. Participation in the PBSTC may contribute to an enhanced training of mental health providers and pastoral ministers, rooted in a primal appreciation of the reality of their own human condition, experienced in the intimate work of empathy, and well-versed in interdisciplinary collaboration. The replication and reevaluation of this modality may also open ground for a simple, community-based operation for the special mixed population of mental health consumers and providers. We consumers and providers have been together for many years in office settings, but separated by desks, and our presumed hierarchical roles. Now we are coming together in the name of the Lord to continue His ever-present liturgy of healing.

“Let all who thirst come; let all who desire it drink from the life-giving water” (Rev 22:17).

**References**


Main, Thomas F. “The Hospital as a Therapeutic Institution.” *Bull. Menninger Clinic* 10 (1946) 66–70.B.