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The Role of Spirituality in Mental Health Interventions: A Developmental Perspective

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This article presents a four-level developmental description of the extent to which clinicians apply spirituality in therapy. At the first level, clinicians begin to sense dissonance regarding their traditional, positivist worldview while conducting conventional psychotherapy, especially in cases involving life-threatening situations or loss. At the second level, clinicians open up to the possibility of the existence of a metaphysical reality and to spiritual/transpersonal beliefs expressed by clients. At the third level, clinicians may cautiously contact this transcendental reality and seek ways to utilize this dimension to access information relevant to therapy. At the fourth level, clinicians actively engage in implementing transpersonal interventions aimed at facilitating change and healing. These levels of integration are delineated along with inherent changes in therapist worldview, perceived professional role, and relevant dilemmas.

There is a large body of empirical evidence suggesting links between spiritual and religious experiences and health (Miller, 1999; Koenig & Larson, 2001; Koenig, McCullough, & Larson, 2001; Pargament, 1997), thus underscoring the important role of patients' spirituality in their mental health. In clinical practice, too, greater attention is being placed on the role of religious faith and spirituality in an effort to humanize psychotherapy (Beck, 2003) and to bring a more comprehensive and holistic approach to intervention (Frame, 2003; Miller, 1999, 2003; Richards & Bergin, 1997, 2004; Shafranske, 1996; Sperry, 2001). Internationally, mental health professional associations have highlighted the need for developing sensitivity to this life dimension (Culliford, 2002) because: "in every human being there seems to be a spiritual dimension, a quality that goes beyond religious affiliation that strives for inspiration, reverence, awe, meaning and purpose, even in those who do not believe in God" (Murray & Zentner, 1989, p. 259).

For example, in a longitudinal study by the Higher Education Research Institute (HERI, 2004) at the University of California, Los Angeles (UCLA),

112,000 undergraduate students at 236 colleges around the United States (US) were surveyed in order to understand their perceptions of spirituality and its role in their lives. Most students demonstrated a remarkably high level of interest and participation in the spiritual domain, with many involved in a spiritual search and/or a search for meaning and goals in life, and reporting a sense of commitment to relevant beliefs. Moreover, they arrived at the university with the expectation that their academic pursuits would further not only accumulation of theoretical or professional knowledge but also enhance their spiritual development.

Similarly in a smaller, clinical sample of "seriously ill" patients with diagnoses including schizophrenia, bipolar disorder, unipolar depression, schizoaffective disorder, and personality disorder (Koenig & Larson, 2001), 60% reported that religion/spirituality, including transpersonal beliefs, had a significant positive impact on their illness.

Thus, there is growing recognition that spirituality represents a central factor in individuals' lives and of the need to take it into consideration in mental health interventions. It is, however, as yet unclear how this

sensitivity to the spiritual domain might be implemented and what might constitute a full acknowledgement of this dimension in individual psychotherapy (see discussions by Corbett & Stein, 2005; Elkins, 2005; Epstein, 1995; Germer, Siegal, & Fulton, 2005; Lukoff & Lu, 2005; Miller, 1999; Shafranske & Sperry, 2005; Welwood, 1985, 2002).

In this paper we present a conceptual discussion of the possible ways by which spirituality might be (and has been) incorporated in mental health interventions. We suggest a developmental approach involving various levels of integrating spirituality into mental health practice. Successive levels denote a more comprehensive and perhaps advanced stage in the introduction of spirituality into the sphere of mental health. The various levels' representation of increased spiritual understanding and use of relevant concepts and techniques in therapy may also be seen to reflect parallel shifts in attitude and practice evident in the world of psychology. They also mirror gradual shifts in the way clinicians perceive themselves as helpers and the nature of the service they provide their clients.

We have identified four such levels of spirituality integration, which can be briefly described as follows: (a) Dissonance: The clinician maintains their traditional materialist position but senses dissonance between its implications and the needs of clients in certain extreme situations; (b) Opening up: The clinician acknowledges the validity of diverse world views, including the existence of a transcendent or transpersonal reality, and passively accepts and responds to clients' spiritual material; (c) Contact with caution: The clinician actively acquires knowledge about the "self in treatment" through various spiritual channels, for example, accessing altered states of consciousness; (d) Engaged: The clinician is able to fully integrate and implement transpersonal interventions to promote health and empower clients.

Each of these levels is related to ontological and epistemological shifts and also involves various ethical dilemmas as to the nature and purpose of intervention and the techniques used, as well as the nature of the relationship between clinician and client change.

Dissonance

One reason for the neglect of the spiritual dimension by mental health professionals has to do with the 19th century positivist worldview regarding the material world as the only existing world. Within this paradigm there was no room for the metaphysical. The soul was basically seen as derived from the physical body or, within

a dualistic approach, as separate but dependent on the body; when the body dies, everything (mental world, soul) ceases to exist. Spiritual experiences and beliefs were mostly seen as reflecting anomalous activity of the mind or brain, or as a sort of delusional belief. In the first case (anomalous mind or brain activity), these experiences or beliefs (e.g., talking to someone who does not exist in material reality) might have been seen as reflecting disease or drug abuse. In the second case (delusional thinking), well functioning individuals who believe in the existence of a metaphysical, transcendental world were often seen as deranged, irrational, or as lying to themselves in this specific domain. Such illogical beliefs were attributed to a fear of death and difficulty to accept the "truth" that we completely cease to exist once we die. Alternatively, when such ideas were part of a recognized religious belief system, their validity was neither contested nor accepted; they were conceived to be outside the domain of valid scientific knowledge: "There are things you know and there are things you believe in" (Mayseless, 2006). (Yet we note that clinical interventions within a religious framework by priests, ministers, rabbis, or pastors did openly acknowledge and use the spiritual and transpersonal dimensions all along, [Koenig, McCullough, & Larson, 2001].)

Interestingly, there were certain situations in clinical practice that seemed to "allow" the use of patients' spiritual beliefs in the existence of a higher power and /or "another reality" without raising undue criticism. These were conditions of existential crisis and life threatening situations such as terminal illness, loss or grief, or contemplation of suicide. In such cases, issues related to meaning, higher purpose in life, the existence of a higher being, life after physical death, and other spiritual concerns are quite common. In the case of suicide contemplation, for example, Birnbaum and Birnbaum (2005) identified central concerns regarding relationship with God (perceived as forgiving, punishing, guiding, or containing), belief in reincarnation, and life after death.

Such situations were open to diverse interventions based on patients' spiritual beliefs or those offered by therapists. Perception of a continuing relationship with a deceased person, a search for a higher purpose or mission in life, and the concept of God or a higher power and its relationship with the individual have long been perceived as intuitive and integral parts of the therapeutic discourse in these particular situations. The same goes for the famous 12-step approach to addictions, which was

built upon acceptance of, and reliance on, a higher power (Miller, 1999).

The question is: Why? What is it in these circumstances that shields them from practitioner resistance and condemnation of “irrational” spiritual beliefs? There seem to be three relevant themes in such life threatening situations that allow clinicians to go beyond their dominant materialist beliefs: (1) These cases are usually perceived as crises that demand individuals’ ultimate inner resources of strength, including their spiritual beliefs, which receive legitimacy in light of the crisis; (2) The human quest for hope in such situations calls for solutions beyond human control and rational perception; if practitioners adhered to their usual reality perception, no hope, solace or consolation would be forthcoming; (3) Compassion towards seriously ill or dying people relaxes practitioners’ judgmental criteria; individuals are given the privilege of observing their lives from a transcendental-holistic perspective without having to worry about being seen as irrational.

In sum, at this first level, spiritual beliefs and concerns are usually not evoked by the clinician but are acknowledged and allowed without criticism due to extreme situations. Of course this delineation is highly prototypical and, hence, may not do justice to the flexibility with which many clinicians actually exhibit when spiritual issues are raised in therapy. The point we are making is that at this level professionals’ typical ontological assumptions (only the material exists; the mental world dies when the body dies) and epistemological beliefs (we cannot get information from deceased people, higher beings, or a cosmic, universal wisdom) significantly limit the therapeutic process. Their influence may be all the more powerful and insidious since they are often not openly acknowledged or stated, yet they are likely to affect both style and content of therapy (e.g., what is considered relevant and solicited in the evaluation and what is not, what receives attention or emphasis and what is downplayed or ignored, what is merely “allowed” and what is reinforced), thus coloring interpretations given, interventions offered, and the entire encounter.

Some relevant questions and dilemmas relating to this level might include: Should clinicians accept “non-scientific phenomena” as legitimate? Should they honor such concerns and worldviews even if they clearly do not share them and actually think that they are fantastic creations of the imagination? For example, if a widow tells a therapist about her conversations with her late husband whom she believes contacts her from the “other side,”

should clinicians (as many do) interpret this as an internal conversation with her representation of her husband, or should they accept the possibility that the deceased actually exists in another dimension and continue from there to explore her possible relations with him in other incarnations?

Opening Up

The second phase in the inclusion of spiritual facets in mental health interventions involves a personal paradigm shift on the part of the clinician. In this stage, therapists can place spirituality and psychology side-by-side. This requires that they relinquish the positivism and empiricism characteristic of the previous stage in favor of a post-modern or existential-humanistic position (Capra, 1983; Lorimer, 1998; Ravindra, 2000). From such a post-positivist view, the clinician can question the validity of 19th century empirical science, realizing that there is no objective reality, only interpretations of realities. Hence, a client’s view of reality—his or her life story or narrative—is what matters, and clinicians cannot and should not disqualify it, just as they cannot and should not convince a client who believes in God or in a certain religious tradition that this is simply a subjective, non-valid belief. According to this view, a spiritual or transcendental reality can be accepted as a legitimate worldview to be explored in therapy if and when the client raises such issues.

If an existential-humanistic view is adopted, and especially if the assumptions of transpersonal psychology are considered (Wilber, 1977), the paradigm shift involves entertaining the possibility that a spiritual sphere actually exists and may be explored. A clinician at this level would assert that if spiritual phenomena or beliefs have any influence on the mental and physical world, there should be no obstacles in the way of assessing this influence via accepted research methodologies (Mayseless, 2006). In line with this view is the large body of research examining associations between spiritual activities such as meditation and varied physical and mental states. Studies have described the impact of meditation on the nervous system, including changes of brain waves, changes of perception, improvement of emotional regulation, and more (Anand, Chandra, & Singh, 1961; Brown & Engler, 1986; Davidson, Kabat-Zinn, & Schumacher, 2003; Kasamatsu & Harari, 1966; Lutz, Greschar, Rawlings, Ricard, & Davidson, 2004).

Scientific inquiry into the relationship between spiritual, mental, and physical aspects of reality has taken many other forms. For example, Sabom (1982) and

vanLommel, Wees, Meyers, and Elfferich (2001) have researched near death experiences. Schwartz and Simon (2002) have conducted experiments examining scientific evidence for life after death via channeling. Stevenson (1997) reported on work with children suggestive of reincarnation. Though these studies may not furnish “conclusive” evidence for spiritual beliefs, they reflect the capacity to apply scientific methodology to the field. One of the most rigorous attempts of this kind is the series of experiments examining “anomalous processes of information or energy transfer” (i.e., telepathy; Bem & Honorton, 1994, p. 4), and Schnidt, Schneider, Utts, and Walach’s (2004) meta-analysis of experiments examining the feeling of being stared at by a distant observer in another room. These experiments provided evidence for a small but reliable effect of information or energy transfer that cannot be explained by current scientific theories.

In accordance with this ontological and epistemological shift (i.e., accepting the possibility that a spiritual realm exists), some researchers have experimented with interventions reflecting such change. An interesting example can be found in a recent study where dreams were interpreted in a series of clinical sessions using either a spiritual or a non-spiritual approach (Davis & Hill, 2005). The study used a controlled pre-post design and concluded by suggesting the “benefit of incorporating spirituality into dream interpretation for spiritually oriented clients” (p. 492). Another intriguing example can be found in the psychomanteum research conducted at the Institute of Transpersonal Psychology in Palo Alto, California (Hastings et al., 2002). A psychomanteum process involving mirror-gazing was used in a research setting to explore the possibility of facilitated contact with deceased friends and relatives and to collect data on these experiences and their effects on bereavement. The process included three stages: (1) talking about memories of the deceased, (2) sitting in a darkened room gazing into a mirror while thinking of the deceased, and (3) discussing the resulting process with the clinician. The study reported strong experiences and a few apparent contacts.

Obviously, such research not only challenges practitioners’ limits in terms of their beliefs, but it may also raise several dilemmas: To what extent should their openness to a metaphysical reality be expressed in the therapy room? Is it necessary for practitioners to stretch and modify their own beliefs in order to meet clients’ spiritual needs and if so, to what extent? Should clinicians raise these possibilities actively or should they wait for

their clients to raise them and then follow them in their clinical interventions?

An example of a clinician engaging his or her client from this second stage may be relevant. A doctor presented for therapy following traumatic exposure to severe physical injuries sustained by a young boy in a biking accident while under his care. After several sessions, the client reported that as he bent over the boy’s body and attempted to tend to his wounds and support him, he experienced the presence of a woman with long white hair telling him that he was in the right place and doing the right thing. He felt surrounded by love and was filled with a strong sense of inner compassion and calm. The therapist had not initiated exploration in such a direction and was not particularly oriented toward such metaphysical phenomena, but he reacted to the client’s statement of his experience with complete acceptance and empathic amazement.

In sum, the second level reflects a conceptual shift that involves ceasing to relate to metaphysical phenomena and altered states of consciousness (channeling and contacts with alternative realities) as pathological responses. The possible acceptance of a metaphysical reality is reflected in the writings of scholars about the fundamental wholeness and interconnectedness of human existence (Capra, 1983; Findlay, 2000; Powel, 2001). These scholars suggested that if we acknowledge the existence of such alter-reality, we should not only respect clients’ experiences in these domains but also ask ourselves as practitioners: What is the meaning of human existence and how do we actively implement our beliefs relating to these domains? Such questions lead us to our third level.

Contact with Caution

At the third level of incorporating spirituality into therapeutic practice, the common relationship between “valid” knowledge and “invalid” knowledge is shattered and spiritual/transpersonal ways of knowing are accepted as legitimate ways of understanding the world, the human experience, and gathering information about them. For example, in such a worldview, the Jungian concepts of the collective unconscious and archetypes might be accepted as legitimate and used as part of clinicians’ interpretations.

The outlook of the clinician at this level corresponds with transpersonal and psychospiritual psychology as first introduced by William James in 1905 (Benson, 1999). As a leading figure in modern psychology,

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