INTEGRATING THE SPIRIT WITHIN PSYCHOSIS: ALTERNATIVE CONCEPTUALIZATIONS OF PSYCHOTIC DISORDERS

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**ABSTRACT:** This literature review integrates theory, research, and treatment regarding spiritual experiences in persons with psychosis. The goal of this article is to further communication amongst mainstream and transpersonal psychologists regarding their approaches toward spirituality and psychosis. Perspectives presented in this paper include Anton Boisen’s pastoral counseling approach, John Weir Perry’s Jungian approach, Stanislav Grof’s and David Lukoff’s transpersonal approaches, research and treatment in mainstream psychology on religious coping and ways to incorporate religious and spiritual issues into therapy. The article also provides a framework to integrate this diverse body of knowledge, and affords some suggestions for future research.

Psychotic and religious experiences have been associated since the earliest recorded history (Lukoff & Lu, 2005). The Old Testament uses the same term to refer to madness sent by God as a punishment for the disobedient, and to describe the behavior of prophets (Rosen, 1968). Socrates declared, “Our greatest blessings come to us by way of madness, provided the madness is given us by divine gift” (Dodds, 1951, p. 61). In more recent years, religious institutions and the mental health field–especially in the West– have taken a more dichotomous view of spirituality and psychosis. When spirituality and psychosis overlap, the experience has usually been viewed as pathological. The objective of this article is to bring together a diverse set of perspectives on the theory, research, and practical applications surrounding religion and spirituality and their relationship to psychosis, in an effort to enhance the quality of care provided to persons encountering such experiences.

**CONCEPTUALIZATIONS OF PSYCHOTIC DISORDERS**

**Previous Approaches to Psychotic Disorders and Spiritual Experiences**

Whether the experience is labeled as pathological or spiritual depends on the culture. Based on a cross-cultural survey, Prince (1992) concluded that:

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Highly similar mental and behavioral states may be designated psychiatric disorders in some cultural settings and religious experiences in others... Within cultures that invest these unusual states with meaning and provide the individual experiencing them with institutional support, at least a proportion of them may be contained and channeled into socially valuable roles. (p. 289)

People who had such experiences may have, in ancient Western, as well as traditional cultures, been esteemed for their spiritual experiences and enjoyed social status as shamans, prophets, visionaries, or saints.

In contemporary Western society, anomalous experiences such as seeing visions and hearing voices, while known to occur during intense spiritual experiences, are often viewed as symptoms of a psychotic disorder. People in the midst of such experiences have difficulty obtaining support from either the healthcare system or religion: “Both Western religion and science lack the cognitive models and language to describe such states in a nuanced way, just as Western culture fails to support those experiencing these states with a viable cultural language” (Douglas-Klotz, 2001, p. 71). Many religions such as some branches of organized Christianity eliminate elements of experiential spirituality. Consequentially, Grof (1986) has suggested that if a member of most congregations were to have a profound religious experience, its minister would very likely send him or her to a psychiatrist for medical treatment.

At the turn of the 20th century, Jaspers, one of the founders of the diagnostic nomenclature and methods used in the current Western mainstream mental health field, referred to an “abyss of difference” between the distorted psychic life of the schizophrenic and others (Jaspers, 1963, p. 219). When religion or spirituality are discussed in the same sentence as the words ‘schizophrenia’ or ‘psychosis’ in the mainstream mental health literature, it typically is in regard to symptomatology and etiology of the disease (Brewerton, 1994; Getz, Fleck, & Strakowski, 2001; Larson & Larson, 1994; Post, 1992; Siddle, Haddock, Tarrier, & Faragher, 2002). Religion and spirituality have also been suspected of exacerbating symptoms of a psychotic disorder (Koenig, McCullough, & Larson, 2001).

Emerging Trends in the Relationship Between Psychosis and Spiritual Experiences

Yet many outside current mainstream Western psychology question this approach. Laing (1982) has criticized placing all emphasis on the presumed patients’ responsibility for making their realities understandable to others: “Both what you say and how I listen contribute to how close or far apart we are” (p. 38). Some individuals who have been through it consider religion and spirituality to be integral in the makeup and working through of psychosis (Lukoff & Lu, 2005; Shorto, 1999). Clinicians with this perspective, mainly transpersonal psychologists, have described psychosis as a natural developmental process with both spiritual and psychological components (Lukoff, 1988; Perry, 1999; Shorto, 1999). They have also pointed out and discussed the
similarity between psychotic symptoms and spiritual experiences (Arieti, 1976; Boisen, 1936; Buckley, 1981; James, 1958).

Both psychosis and spiritual experiences involve escaping the limiting boundaries of the self, which leads to an immense elation and freedom as the outlines of the confining selfhood meltdown. The need to transcend the limiting boundaries of the self has been postulated as a basic neurobiological need of all living things (Newberg, D’Aquili, & Rause, 2001). However, in persons with psychotic disorder, “the sense of embodied self is transcended before it has been firmly established...disintegration and further fragmentation are the likely results” (Mills, 2001, p. 214). Some psychotic experiences are better understood as crises related to the person’s efforts to break out of the standard ego-bounded identity: “trials of the soul on its spiritual journey” (House, 2001, p. 124–125). Anthropologists have documented how such experiences sometimes lead to a revitalization within a culture (Wallace, 1956).

Some mainstream researchers and practitioners have taken a new look at religion and spirituality in persons with psychotic disorders (Fallot, 1998; Kehoe, 1998; Phillips, Lakin, & Pargament, 2002). They have begun to show how religion serves as a resource for individuals coping with psychosis (Fallot, 1998; Phillips & Stein, 2007). Mainstream practitioners have recently created therapy programs for persons with serious mental illness (SMI) that address religious and spiritual issues (Kehoe, 1998; Phillips, Lakin, & Pargament, 2002). These therapists help mental health consumers discover and share their spiritual resources, believing that clients’ spirituality can help them grow and cope with their mental difficulties. They also recognize that individuals’ religion may add to their struggle, but that through therapy a person can work through these issues, at least to some degree.

The experience of something that is greater than the self, something more powerful, has been alternately viewed as transpersonal, spiritual, religious, sacred, mystical, divine, archetypal, or mythical (Pappas & Friedman, 2007). Theorists have noted some differences amongst these terms. Many consider religion to refer to an organized social group that focuses on the transcendent through practice of a set of rituals, a specified doctrine, and a community of believers, whereas spirituality refers to an individual’s personal experience of a relationship with the transcendent or a higher power (Zinnbauer et al., 1997). The terms will be used as they are presented by each theorist, researcher, or practitioner. The purpose of this review is to bring together these approaches, examining how each group relates psychosis to the transcendence of the self.

INTEGRATING SPIRITUALITY INTO TREATMENTS FOR PSYCHOSIS

The Work of Anton Boisen: Founder of Pastoral Counseling

Perhaps the earliest proponent of addressing spirituality within the treatment of psychosis was the pastoral counselor Anton Boisen. Boisen spent time in a
mental institution after experiencing his own break from reality. In his book *The Exploration of the Inner World* (Boisen, 1936), he described his feelings of terror and disturbance and how he overcame his crisis over the rupture in his worldview. He described his psychotic experience as a religious and spiritual problem solving process. Only after some time in the hospital, reconstructing his worldview, did he find inner peace and begin to function better. Yet his experience left him with sympathy for his peers in the hospital. He knew his religious crisis met with a positive outcome, but for many in the hospital it had not. He noted many historical religious leaders had experienced their own times of upheaval that led to a transformative resolution. Boisen (1936) wondered if many of the patients were unable to find a satisfactory solution to the same religious problems. With help, could they too find a better ending to their spiritual crisis?

Boisen explored the implications of his thesis about the spiritual struggle of individuals with psychosis in different social service institutions around the country. He conducted research exploring the symptoms experienced by hospital inpatients, noting such patterns as social withdrawal, delusions of grandeur and world doom, along with profound despair and hopelessness. Boisen (1936) theorized that there are two types of schizophrenia – one that is correctly labeled by the mental health community as an organic disturbance, and another, unrecognized by the mental health system, that is a natural religious problem-solving method for coping with overwhelming difficulties that did not fit the person’s current worldview. The shock to the psychological system left the person in the throes of psychosis, but a type that is a natural and purposive phenomenon. Boisen suggested the therapist should not hinder the natural process, instead removing obstacles that could prevent the experience from unfolding.

Boisen applied his theoretical and research positions by training seminary students to serve in psychiatric hospitals (Boisen, 1936). He led church services with sermons and music relevant to the psychiatrically hospitalized population – songs dealing with feelings of inner turbulence. He started a patients’ choir and supervised the seminarians to help them find ways to listen to the spiritual struggles of the patients. He focused on an empathic and friendly relationship, not a hierarchical one. Boisen (1936) reported that the patients seemed to benefit from the work, although no data were collected. Boisen laid the groundwork for future mental health practitioners by recognizing that there may be a unique form of psychosis that especially relates to spirituality, and that addressing spiritual issues in such cases could benefit the individual.

*Diabasis and Soteria House: Jungian and Existential Approaches*

Boisen’s work was followed in the 1970’s by the Jungian analyst John Weir Perry. Similar to Boisen, Perry considered the psychotic process to be a natural problem-solving process due to a breakdown in the person’s worldview. Perry
(1974) explored psychosis from a Jungian framework and noted that some psychotic breaks were spiritual in nature, with hallucinations and delusions that contained mythic or archetypal themes holding power and meaning. Perry (1974; 1999) documented how the themes in psychotic experience are also found in mythology and religious traditions.

Some research has supported the similarity between symbols found in myth and psychosis across different cultures (Billig, Gurton-Bradley, & Doerrmann, 1976). Through case studies of approximately 20 psychotic patients, Perry (1974) found themes including the destruction of the world, a cosmic fight between good and evil, the appearance of a messiah that the client identifies him/herself with, and a sense of rebirth of the world into a more loving place. The purpose of these mythic motifs was similar for both the individual and society – a transformation of a way of life. Perry (1974; 1999) described the early family experiences of these patients as judgmental and unloving. For these patients who worked through the psychotic experience, a new worldview emerged, one more accepting and kind towards the self and others.

Perry's model is based on the finding that the psychotic phase in some individuals is temporary, a symbolic vision quest that initiates changes that are on the horizon for the person. If the process can be explored instead of squelched with medication and lack of acknowledgment, then a return to higher levels of functioning might be possible in some individuals with psychosis. Perry created a group home residence called Diabasis for individuals presenting with recent onset psychosis (Perry, 1974; 1999). Only non-mental health professionals were hired to assist the clients, as Perry believed educated clinicians had embedded conceptualizations of schizophrenia that would only interfere with their ability to follow such a novel treatment approach. Perry looked for staff members who were open to diverse life experiences, sociable, and good listeners. The staff members’ duties included acting as caretakers (helping oversee cooking, cleaning, etc.) as well as functioning as therapists. The residence consisted of a typical living facility (bedrooms, kitchen, living room) with the addition of a ‘venting room’ that encouraged residents to express their concerns, no matter how intense. Therapy, conducted thrice weekly, consisted of listening to clients and helping them interpret the powerful and spiritual symbols within their hallucinations and delusions. Medication was not utilized. Clients had to be younger adults with little previous experience with the mental health system (for reasons similar to the hire of therapists). Clients were referred from area clinicians or hospitals.

Perry (1999) has published some data on the program, which closed down after a few years due to budget cutbacks in the mental health system. The average length of stay was 48 days. He reported that severely psychotic clients became coherent within two to six days without medication. The outcomes appeared better for those who had had fewer than three previous psychotic episodes. Unfortunately, other quantitative data were not collected for this sample.

A similar program, Soteria House, located in San Jose, California, provided more empirical support for this model (Mosher & Menn, 1978; 1979). Soteria
House ran from 1971–1983, roomed six clients, with three to four staff on premises at one time. Most staff were nonprofessionals, chosen because of their lack of exposure to the medical model in mental health treatment (to which Soteria House did not adhere). Other criteria for staff included being “psychologically tough” (willing to sit with unusual behaviors and beliefs) and good at listening. The staff was trained to recognize that psychotic experiences were a developmental stage that can lead to growth, often containing a spiritual component of mystical experiences and beliefs. Central to recovery in the Soteria model was the development of a strong, positive, nonhierarchical relationship between staff and clients. Thus, counselors were taught to listen and support clients in their search to make sense of their psychotic experience and find their own answers. Clients were given as much control over their situation as possible (e.g., they were allowed to attend staff meetings and shop for their own food). Medication was typically not prescribed unless a client showed no improvement after six weeks (only 10% of clients used medication at Soteria), since it was believed to stunt the possible growth-enhancing process of the psychotic episode (Mosher & Menn, 1979). Limits were set if clients became a danger to themselves or others. A project director and quarter-time psychiatrist were also employed.

Outcomes from Soteria were compared to a ‘traditional’ program, a community mental health center inpatient service consisting of daily pharmacotherapy, psychotherapy, occupational therapy, and group therapy (Mosher, Menn, & Mathews, 1975). After a few weeks clients in the traditional program were referred for outpatient care, including partial hospitalization or halfway houses. Criteria for admission to either program required patients to be unmarried, between the ages of 15 to 30, diagnosed with schizophrenia and in need of hospitalization. Due to practical considerations, random assignment of clients to each treatment program was not used (at times, there were no beds available in the Soteria program). However, there were no significant differences across demographic and psychopathological variables at admission between the two groups (Mosher & Menn, 1978). Clients’ length of stay was longer at Soteria than in the comparison program (mean of 166 days versus 28 days, respectively) (Mosher & Menn, 1978). But most of the patients recovered in 6–8 weeks without medication (Mosher, Hendrix, & Fort, 2004).

A two-year follow-up study compared client outcomes across the two programs. Thirty-three clients from Soteria were compared with 30 clients from a psychiatric hospital. An independent outside evaluation team conducted the assessment, although the authors report it was impossible to make them blind to the treatment (Mosher & Menn, 1979). Four major differences were found. First, fewer Soteria subjects were using antipsychotic medication (4%) two years after admission than control subjects (43%). Second, Soteria participants were less likely to be using mental health services. These two results were interpreted by the authors as an indication that clients were not in need of these services, although an alternative conclusion is that clients were in need of these services but did not utilize these resources. A third divergence between the two groups was that Soteria clients had significantly higher ratings on occupational status at the end of the two-year time period.
compared with individuals treated in the control program. The fourth significant distinction was that Soteria clients were more likely to be living on their own or with a peer at two-year follow-up than were members of the control program, who were more likely to be living at home with their parents (Mosher & Menn, 1978; Mosher, Menn, & Mathews, 1975). There was not a significant difference between the programs on clients’ level of pathology at two-year follow-up. Yet both groups had significant declines in symptoms over the two-year time span (Mosher & Menn, 1979).

In a randomized study of both Soteria House and a replication program (Emanon) also located in California (Mosher, Vallone, & Menn, 1995), declines in pathology six weeks after discharge were significant and at levels comparable to a hospital located near each experimental facility. Improvements in functioning for those patients in the Soteria program were significantly higher 6 weeks from discharge, increasing at a rate similar to those experiencing hospitalization (Mosher, Vallone, & Menn, 1995). It appears that treatment that allows psychosis to be ‘worked through’ by treating it as a powerful transformative process can work as well as current mainstream forms of intervention.

A recent meta-analysis of data from two carefully controlled studies of Soteria programs found better 2-year outcomes for the randomly assigned Soteria patients in the domains of psychopathology, work, and social functioning than for similar clients who were treated in a psychiatric hospital. Only 58% of Soteria subjects received antipsychotic medications during the follow-up period, and only 19% were continuously maintained on antipsychotic medications (Bola & Mosher, 2003).

**Grofs and Lukoff: The Transpersonal Perspective**

Transpersonal clinicians have viewed some psychotic experiences as temporary and possibly leading to improved functioning when individuals are provided with appropriate forms of intervention. For instance, Stanislav and Christina Grof have described the spiritual emergency as a crisis often resulting in intense emotions, unusual thoughts and behaviors, and perceptual changes (Grof & Grof, 1989). This crisis often contains a spiritual component, such as experiences of death and rebirth, unity with the universe, and encounters with powerful beings. Such crises bring the potential for profound psychological and spiritual change (Grof & Grof, 1989), but often appear similar to psychotic disorders.

Spiritual emergencies can be a normal and life-enhancing phase of development, and lead to a greater capacity for love, compassion, wisdom, and equanimity if given the proper treatment (Grof & Grof, 1989). Spiritual emergencies often come about after a spontaneous spiritual experience, such as episodes of mystical consciousness, near-death experiences, and communication with spirit guides, as well as after intensive spiritual practices such as meditation or yoga leading to awakening of Kundalini energy (Grof & Grof, 1989).
Grof and Grof (1989) highlighted the importance of using psychological and spiritual interventions for working through a spiritual emergency. For instance, Kornfield (1989) describes a Buddhist approach for dealing with spiritual emergencies. One technique is to be mindful of the experience, labeling it without fully identifying with the painful experience. To maintain balance, grounding oneself through bringing attention to the body and the earth is also recommended, as described in the following case example (Kornfield, 1989):

An “overzealous young karate student” decided to meditate and not move for a full day and night. When he got up, he was filled with explosive energy. He strode into the middle of the dining hall filled with 100 silent retreatants and began to yell and practice his karate maneuvers at triple speed. Then he screamed, “When I look at each of you, I see behind you a whole trail of bodies showing your past lives.” As an experienced meditation teacher, Kornfield recognized that the symptoms were related to the meditation practice rather than signs of a manic episode (for which they also meet all the diagnostic criteria except duration). The meditation community handled the situation by stopping his meditation practice and starting him jogging, ten miles in the morning and afternoon. His diet was changed to include red meat, which is thought to have a grounding effect. They got him to take frequent hot baths and showers, and to dig in the garden. One person was with him all the time. After three days, he was able to sleep again and was allowed to start meditating again, slowly and carefully. (pp. 131–132)

Lukoff (2005) has presented criteria for differential diagnosis of visionary spiritual experience (VSE) from psychotic disorders. The VSE typically includes ecstatic mood, a sense of newly gained knowledge, and delusions with spiritual themes (which most psychotic disorders do not include). Unlike psychotic disorders, VSEs have “good pre-episode functioning, acute onset of symptoms during a period of three months or less, [a] stressful precipitant to the psychotic episode, [and] a positive, exploratory attitude toward the experience” (Lukoff, 2005, p. 242). Further, there must be no significant risk for homicidal or suicidal behavior in a VSE.

Lukoff (2005) described some specific transpersonal interventions with spiritual emergencies and VSEs. A therapist should normalize the experience, helping the client understand the spiritual emergency can be a positive and helpful experience, clarifying that it is not a mental illness. The practitioner should provide a therapeutic container, showing empathy and appreciation for the process of the spiritual emergency in order to prevent its stifling. The therapist tries to help the clients find meaning in their symptoms (Lukoff, 1988; Lukoff & Everest, 1985). For instance, Lukoff co-wrote an article with a client describing the mythical nature behind his symptoms (Lukoff & Everest, 1985). Often meaning can be found through creative expression, such as drawing and poetry (Lukoff & Everest, 1985; Lukoff, 2005). Limiting environmental stimulation and temporarily discontinuing spiritual practices can be of aid. Grounding the client by eating heavy foods (beans, grains, dairy, and meat), and engaging in simple activities like gardening or hiking can help.
Lukoff considered how individuals with diagnoses of schizophrenia could also benefit from treatments that acknowledged the spiritual side of their lives. He contrasted the effectiveness of a 12-week holistic health program with a social skills training group, randomly assigning schizophrenic inpatients at a state mental hospital to either treatment (Lukoff, Wallace, Liberman, & Burke, 1986). Both groups were given medication. The holistic program consisted of 20 minutes of daily yoga exercises as well as 20 minutes of meditation. Clients were given the choice between 16 different mantras. Clients also received a Mobilizing Positive Beliefs session once a week as part of the holistic health group. Clients were given images suggestive of harmony and healing, and encouraged to create their own images in visualization and art therapy. Weekly “Growth and Schizophrenia” sessions helped members look at the positive dimensions of their hallucinations and delusions. This included exploring the experiences of shamanic initiatory crises and Native American vision quests, and how individuals with similar symptoms throughout history have contributed to society in religion and art. Other activities included daily exercise and weekly meetings to boost self-esteem, as well as a weekly family therapy session (Lukoff et al., 1986).

The outcomes found in this program demonstrated the value of viewing the psychotic experience as an opportunity to grow, as well as the usefulness of integrating spirituality into the treatment process. Both the holistic and control groups had significant reductions in symptoms (Lukoff et al., 1986). The members of the holistic group showed trends suggesting greater decrease of symptoms than the social skills training group but these did not reach significance. The groups also did not significantly differ on relapse rates, levels of self esteem, use of medication, or blood pressure. The authors suggest these results demonstrate that an alternative program integrating spiritual components into treatment of schizophrenia can help as much as traditional interventions. Indeed, the authors were most impressed that inpatients in the holistic group responded positively to meditation, given that others reported that meditation could cause distress in persons suffering from psychosis (Walsh & Roche, 1979). Overall, the study provided some support to the idea that spiritual interventions can be used in persons with schizophrenia without causing harm, and with possible benefits.

Lukoff and Grof & Grof expand on the work of Boisen, Perry, and Mosher. They provide specific criteria for identifying religious types of psychoses (spiritual emergencies) and to differentiate them from schizophrenia. Transpersonal psychologists have provided a unique set of interventions for dealing with such episodes. Although empirical research on transpersonal therapies for spiritual emergencies is in its infancy, early results are promising. Recently, a subset of cognitive-behavioral and psychodynamic practitioners has also begun to integrate spiritual issues into treatment for persons with psychosis (Clarke, 2001; Kehoe, 1998).

Mainstream Integrations of Spirituality into Treatment for Psychosis

“Spiritual issues groups” for persons with serious mental illness (SMI) have begun to appear in mainstream scientific literature (Bussema & Bussema, 2000;
Freeman, Wolfson, & Affolter, 1998; Genia, 1990; Kehoe, 1998; Lindgren & Coursey, 1995; O’Rourke, 1997; Phillips, Lakin, & Pargament, 2002). These programs have ranged from time-limited sessions of a psychoeducational format (Freeman, Wolfson, & Affolter, 1998; Lindgren & Coursey, 1995; Phillips, Lakin, & Pargament, 2002) to longer-term interventions of a psychodynamic nature (Kehoe, 1998; O’Rourke, 1997). Unlike some of the transpersonal therapies, these groups clearly demarcate the boundaries by not including religious or spiritual practices in the treatment session itself (Kehoe, 1998; Phillips, Lakin, & Pargament, 2002). These programs have focused on understanding the religious identity and experiences of those with SMI and how it affects their lives. The programs value religious questioning and tolerance of different points of view (Genia, 1990; Kehoe, 1998; O’Rourke, 1997). There is a balance of exploring both religious resources and spiritual struggles in these groups. Questions such as “Is it OK to be angry with God,” and “If God loves, then why is there suffering” are explored to normalize such concerns and assuage their guilt (Kehoe, 1998). It is a place for clients to discuss and heal from their spiritual struggles, such as feeling abandoned by God or ostracized by their congregation (O’Rourke, 1997; Phillips, Lakin, & Pargament, 2002). It is also an opportunity for them to discuss their positive religious experiences, which may enhance their self-esteem and sense of self-worth (Lindgren & Coursey, 1995; Phillips, Lakin, & Pargament, 2002). Finally, the group differentiates religious delusions from helpful religious coping strategies (Kehoe, 1998; Lindgren & Coursey, 1995).

There are key assumptions in these groups that differ from previous beliefs in mainstream applied psychology. The first assumption is that persons with SMI are just that – persons. The majority of Americans hold some spiritual or religious interests, and persons with SMI are no exception (Kirov, Kemp, Kirov, & David, 1998; Kroll & Sheehan, 1989; Lindgren & Coursey, 1995). Many persons with serious mental illness would like the opportunity to discuss spiritual issues in therapy. Indeed, some participants in these groups have noted that this was the first time they had been encouraged to discuss spiritual issues in counseling and were grateful for it (Phillips, Lakin, & Pargament, 2002). A second assumption is that religion and spirituality can help people with SMI in some situations. As noted in detail in the next section of this paper, research has begun to validate this assumption. Certain religious beliefs and spiritual behaviors are consistently associated with positive adjustment to living with psychosis (Fallot, 1998; Phillips & Stein, 2007; Pieper; 2004, Sullivan, 1993). Third, it is assumed that discussing how religion and spirituality are causing problems in a client’s life and finding ways to deal with that could actually help clients with SMI rather than harm them. As noted later in this section, initial reports are that clients with SMI do indeed benefit from discussing their spiritual struggles.

These assumptions run counter to traditional mental health approaches for schizophrenia in which discussing religion and spirituality is believed to make persons with psychoses more delusional and distressed. Kehoe (1998) noted her staff’s concern about initiating a religious group for persons with serious mental illness for fear of worsening symptoms, including delusions. Indeed,
when examining the relationship between religion and schizophrenia, many studies have focused on the religious content of patients’ psychotic symptoms (Brewerton, 1994; Getz, Fleck, & Strakowski, 2001; Siddle, Haddock, Tarrier, & Faragher, 2002). Yet these fears seem unfounded, as multiple therapists who have run spiritual issues groups for persons with schizophrenia and other serious mental illnesses report that they observed no increase in religious delusions in their clients (Freeman, Wolfson, & Affolter, 1998; Kehoe, 1998).

Research on the impact of spiritual issues groups for persons with serious mental illness has been mostly qualitative. Members report multiple benefits, including feeling a sense of connection and support amongst themselves (Lindgren & Coursey, 1995; O’Rourke, 1997; Phillips, Lakin, & Pargament, 2002). Clients report that they recognize they are not alone in terms of their spiritual struggles and the need for religion in their lives (Kehoe, 1998; Phillips, Lakin, & Pargament, 2002). Others noted an increased sense of self-worth and self-esteem (Lindgren & Coursey, 1995; O’Rourke, 1997). Members reported feeling respected and listened to (Phillips, Lakin, & Pargament, 2002). Many reported that they obtained a more fully integrative treatment that was sensitive to the spiritual side of their lives (Phillips, Lakin, & Pargament, 2002). Staff concurred, saying that such a group was important because it focused not on clients’ deficiencies but on highlighting their abilities and strengths (Kehoe, 1998). Some consumers described this treatment as unique in meeting previously unaddressed spiritual needs (Kehoe, 1998). In fact, a time-limited group led by the first author met with such success that the group was extended for over two years at the request of the participants. Eventually the group ended, as all members seemed to ‘graduate,’ and the author literally graduated, thus putting an end to the group.

Lindgren & Coursey (1995) provide some quantitative data on the effects of a spiritual issues group for people with SMI. Confirming the qualitative feedback from facilitators and group members, they found that the intervention increased consumers’ sense of spiritual support. They also noted that the stronger the sense of cohesion in the group, the less depression reported by clients (Lindgren & Coursey, 1995).

Treatment outcome research on the integration of spiritual and religious elements in treatment with persons with SMI is in its infancy. There are limitations to the above studies (e.g., lack of control groups and long-term quantitative follow ups) and further research is needed to support the efficacy of such approaches. Nonetheless, the work being carried out by these mainstream psychologists is promising. A growing number of mainstream mental health practitioners are recognizing the need to explore spirituality in persons with SMI, and setting the stage to demonstrate its treatment efficacy.

Both mainstream and transpersonal clinicians take a similar view regarding content – they both recognize the importance of that which is beyond the individual suffering the psychotic break – whether the term used is transpersonal, mythical, religious, or spiritual. But the difference between mainstream mental health workers and transpersonal therapists lies in the

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process of the intervening. The therapeutic techniques of the mainstream spiritual issues groups operate on a different level than the transpersonal practitioners.

Wilber’s (1984) model of treatment modalities for the basic structures of consciousness provides a means of analysis. Mainstream mental health practitioners seem to be engaging in lower-level interventions such as structure-building techniques (Wilber’s Fulcrum 2 interventions), uncovering methods (Fulcrum 3), and cognitive script analysis (Fulcrum 4) (Wilber, 1984). For instance, the group led by Phillips, Lakin, & Pargament (2002) examined spiritual resources that could be used to build structure and routine into the lives of participants (Fulcrum 2 intervention). This group also utilized cognitive techniques, examining members’ religious attributions of their mental health difficulties and using spiritual meaning-making strategies that help one move forward (Fulcrum 4 intervention). For instance, members who believed that their mental illness was a punishment from God were encouraged to look at how they have grown spiritually by having such difficulties. Kehoe (1998) used psychodynamic means to build the client’s awareness (Fulcrum 3 intervention) and ego (Fulcrum 2 intervention). This is in contrast to a Fulcrum 5 treatment for psychosis at Soteria House, in which empathic and humanistic methods were used extensively, letting clients find their own answers (Mosher & Menn, 1979). Diabasis would be considered more of an existential approach, examining the symbolism behind a particular delusion or hallucination (Perry, 1999). This would be considered a Fulcrum 6 intervention in Wilber’s model. Many nontraditional therapies avoid medication in certain forms of spiritual emergencies and visionary spiritual experiences, considering pharmacotherapy to stall the transformative process. This belief was noted as a component of the Fulcrum 7 treatment modality (Wilber, 1984). Publications concerning mainstream spiritual issues groups do not address the benefits of abstaining from medication. Lukoff’s (1988) and Grof & Grof’s (1989) transpersonal approaches seem to use Fulcrum 7 interventions or higher in Wilber’s model, attempting to help the individual experience the divine. Such treatment techniques include engaging in spiritual practices such as meditation, yoga, and even petitionary prayer (Grof & Grof, 1989; Lukoff, 2005; Wilber, 1984). Therefore, one important distinction between the mainstream and transpersonal treatment approaches is that transpersonal interventions allow for spiritual experiences in therapy, whereas mainstream approaches keep transcendent phenomena on an intellectual level. It is no wonder, then, that transpersonal therapists often use terms such as spirituality when discussing the transcendent, given the experiential association with that term. In contrast, mainstream practitioners often refer to the transcendent with the word religion, which, as noted earlier, is considered a more social concept.

Wilber’s Fulcrum model provides one way to integrate the treatment techniques of mainstream mental health care and transpersonal therapies. Depending on the need of the client, therapists can vary their intervention. Future research should examine if Wilber’s fulcrum model is helpful by assessing whether clients at different levels of functioning and development improve best from the corresponding postulated type of intervention.
Researchers have examined other links between the sacred and psychosis, such as the similarities between spirituality and psychosis (Clarke, 2001), and how individuals use religion to cope with serious mental illness (Pargament, 1997). These connections will be explored in the next section.

**Research on Spirituality and Psychosis**

**Similarities Between Spirituality and Psychosis**

Research has confirmed the overlap between psychotic and spiritual experiences. Peters, Joseph, & Garety (1999) assessed the incidence of delusions using a standard interview and rating criteria among members of New Religious Movements (NRMs such as Moonies), nonreligious people, Christians, and patients hospitalized for psychotic disorders. They found that those in the NRM group could not be distinguished from the inpatients by the presence of delusions, but could by their higher level of distress.

In another study, religious experience and psychopathology were compared across three groups, matched for age and gender: 30 psychotic patients at a psychiatric hospital, 30 religious contemplatives, and a comparison group of individuals in the United States. The contemplatives were “nationally recognized” Buddhist meditation teachers, Hindu center directors, and Christian monks and nuns. The psychotic inpatients and religious contemplatives had similar scores on a measure of mysticism, and both these groups scored significantly higher than the comparison group. The patients had significantly lower levels of adjustment than the other two groups (Stifler, Greer, Sneck, & Dovenmuehle, 1993). These results suggest that many of the inpatients could have been struggling with the religious issues that Boisen, Perry, Lukoff and others have posited.

Detailed cases showing that psychotic symptoms can occur in the context of spiritual experiences rather than mental illness have been published by Jackson & Fulford (1997) and Lukoff (1985; 1991; 1996). Greenberg, Witzum, & Buchbinder (1992) describe four young men who explored Jewish mysticism and became psychotic. Their hallucinations, grandiose and paranoid delusions, and social withdrawal were indistinguishable from those of many mystics. Pathological and spiritual phenomena cannot be distinguished by form and content, but need to be assessed in the light of the values and beliefs of the individual and the social context.

**Research in Mainstream Psychology: Religious Coping and Serious Mental Illness**

Contemporary research on religious coping has documented the value of spirituality for persons with SMI. Most of the studies have employed qualitative methods or simple questionnaires using closed-ended items, while a few studies have used validated scales of religion and spirituality. Sullivan (1993)
interviewed 40 individuals with SMI who were considered to be in recovery (living on their own, working or going to school, having avoided psychiatric hospitalization for at least two years). Using an ethnographic research method, he found that 19 out of 40 individuals spontaneously reported that their religious beliefs and behaviors helped them recover. In another study, almost two thirds (61%) of a group of 52 psychotic inpatients in the United Kingdom reported they used religion to maintain or enhance their mental health (Kirov, Kemp, Kirov, & David, 1998). Eighty percent of a group of 406 individuals with SMI in Los Angeles reported that their religious beliefs or behaviors helped them cope with their symptoms (Tepper, Rogers, Coleman, & Malony, 2001). Thirty percent of this group agreed to the statement that religious beliefs and practices “were the most important thing that kept [them] going” (Tepper et al., p. 662).

Some benefits from religion include feelings of optimism and comfort from giving up some sense of control over the difficulties surrounding SMI, instead placing that control in the belief of a divine force (Sullivan, 1993). Sullivan (1993), as well as others, noted that for persons with SMI, spirituality provides a sense of connection and support through contacts with like-minded individuals (Bussema & Bussema, 2000; Fallot, 1998) and a higher power (Fitchett, Burton, & Sivan, 1997). Hope and security can also be derived from religious figures and texts that provide a model for persevering in the face of adversity, and attributing difficult life circumstances to part of a divine plan in which the individual has a purpose (Fallot, 1998).

Yet religion and spirituality can sometimes be dysfunctional for persons with SMI. Themes of religious guilt and persecution are not uncommon in psychosis (Sullivan, 1993), and others have legalistic and highly inflexible spiritual belief systems, or grandiose religious delusions (Sullivan, 1993). Twenty-seven percent of a sample of 52 psychiatric inpatients believed that their illness was a punishment from God for wrongs they have done (Sheehan & Kroll, 1990). Some felt ostracized from their religious community, while others felt angry at God (Bussema & Bussema, 2000).

Some recent quantitative studies provide objective data to support the claims that religion and spirituality can be both an aid and a challenge when dealing with psychosis and other serious mental problems. Tepper and colleagues (2001) found a positive relationship between general religious coping methods and outcomes; the more time spent utilizing religion to cope with mental problems, the fewer symptoms patients reported. However, some specific religious coping activities were associated with poorer outcomes. For instance, those who prayed the most had lower GAF scores, and those who met with their spiritual leaders more frequently were more likely to report distress (Tepper et al., 2001).

Some recent studies have used established measures of religious coping with persons who have SMI. Pieper (2004) used the Religious Problem Solving Scale (Pargament et al., 1988) to explore issues of control and spirituality in psychiatric inpatients in the Netherlands. The inpatients reported rarely using two religious problem solving methods that have been associated with poorer
outcomes in other samples: (a) deferring religious coping in which individuals place their concerns in the hands of a higher power and believe they should submit control to a divine plan; and (b) self-directing religious coping in which individuals rely on themselves and believe that the divine has the capacity to help them deal with stress. Inpatients were more likely to use a third form of religious problem solving to deal with stress – collaborative religious coping in which individuals work with the divine by doing what they can and expecting help from a divine force with obstacles out of their control. The inpatients used this method at rates similar to the general population (Pargament, Koenig, & Perez, 2000). This method of coping has traditionally been associated with better adjustment to stress. Likewise, inpatients in Pieper’s study (2004) who reported engaging in more collaborative religious coping also reported greater psychological and existential well-being.

Another study, using a longitudinal design, examined religious attributions and their relationship with adjustment to serious mental illness. Phillips & Stein (2007) provided subscales of the RCOPE (Pargament, Koenig, & Perez, 2000), a validated measure of religious coping, and established measures of psychological adjustment to young adults living with bipolar disorder and schizophrenia in 2000 (Time 1) and again one year later (Time 2). These participants were just as likely as nonpsychiatric samples from previous studies (Pargament, Koenig, & Perez, 2000) to use benevolent religious reappraisals (viewing one’s challenges such as mental illnesses as part of a divine plan and an opportunity to grow spiritually). This form of spiritual coping has traditionally been associated with beneficial outcomes from a stressful life event (see Pargament, 1997, for a review), and was related to better outcomes in the current study as well. Examining correlations between measures given at the same time (e.g., contrasting Time 1 benevolent religious reappraisal scores with Time 1 well-being), benevolent religious reappraisals were correlated with greater psychological well-being and personal growth from having dealt with mental illness. Participants’ benevolent religious reappraisal score at Time 1 (2000) did not significantly predict the measures of adjustment one year later, however. In terms of other religious attributions, this sample of individuals with SMI was more likely to believe that their mental illness was a punishment from God than prior nonpsychiatric samples (Pargament, Koenig, & Perez, 2000). When examining measures at the same point in time, punishing God reappraisals were linked to higher levels of distress and greater feelings of loss of a normal life from having mental illness. Further, participants’ Time 1 punishing God reappraisal score predicted distress and loss of a normal life one year later (Phillips & Stein, 2007).

These studies suggest that research in the field of religious coping is uncovering the importance of spirituality in persons with SMI. Researchers are recognizing that religion and spirituality can have both a negative and a positive impact in living with serious mental illness.

It is possible to integrate the mainstream psychological theory of religious coping and some of the transpersonal and Jungian psychological concepts. Pargament
(1997) has described transformational religious coping, which involves aspects of religion and spirituality that call for a radical change in living, a change in the major objectives in life (‘ends’) and ways to obtain these end states (‘means’). Certain psychotic states, such as those described by Perry (1999) and Grof & Grof (1989), could fall within these criteria. The psychotic break in this situation is a spiritual crisis and involves the restructuring of one’s worldview. Pargament (1997) spoke mostly of traditional conversion experiences and rituals of purification and forgiveness as examples of transformational religious coping. Spiritual emergencies may be another form of religious coping that can lead to transformation. Researchers could examine the possibility of spiritual emergencies as a religious coping method to gain transformation. With further refinement, mainstream psychological theory as well as research may be able to integrate transpersonal insights regarding the spiritual foundation of some psychotic episodes. Indeed, Lukoff & Lu (2005, p. 187) predicted that “[i]n the future, transpersonal clinical approaches will greatly expand and evolve, often without using transpersonal psychology constructs.” Today, we are seeing the exploration of transpersonal issues in the guise of “religious coping” and “spiritual concerns,” not only within traditional psychological theory and research, but also in the realm of assessment and treatment.

CONCLUSION

The first author will never forget the reaction when his time-limited spiritual issues group for persons with SMI came to an end. Participants were sad, and one noted: “It seems like a most important door has finally been opened for us, and now it is being slammed shut.” We want to make sure that door re-opens, and stays open. For too long, persons with SMI have had, at best, the spiritual side to their lives ignored. The purpose of this review is to summarize these approaches and provide opportunities for exchanges of information amongst researchers, theorists, and practitioners who work with individuals with SMI and visionary spiritual experiences. Further dialogue can lead to the development of more effective and sensitive approaches in the treatment and research in persons with these mental health problems, which can only benefit those we serve, as well as their families and friends.

REFERENCES


Fallot. (1998). Spiritual and religious dimensions of mental illness recovery narratives. New Directions for Mental Health Services, 80, 35–44.


MOSHER, L. R., & MENN, A. (1979). Soteria: An alternative to hospitalization for schizophrenia. New Directions for Mental Health Services, 1, 73–84.


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