Integrating Religion and Spirituality in Mental Health: The Promise and the Challenge

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Abstract

Today's mental health system is largely a product of western science. Like a one-eyed giant, it has great power, but it lacks the wisdom which makes life sacred and meaningful. The challenge for today's mental health system is to unite East and West; to integrate wisdom and science; to make room for the sacred as well as the practical. One of the most critical domains for integration – and one of the most difficult to address – is the area of religion and spirituality. The purpose of this paper is to review the historical tension concerning the integration of religion and the science of mental health; to explore current social trends that are creating new opportunities and pressures to move in this direction; and to discuss strategies for the integration of religion and spirituality in mental health services and practice.

In an introduction to the writings of Mahatma Gandhi, Thomas Merton compared the white man's arrival into Africa (and Asia and America) to a "one-eyed giant, bringing with him the characteristic split and blindness that were at once his strength, his torment and his ruin" (Merton, 1964). Western civilization, Merton claimed, was the "master of concepts and the king of quantity." It had science without wisdom, and rapidly overwhelmed cultures that had wisdom without science.

Today's mental health system is largely a product of western science. Like a one-eyed giant, it has great power, but it lacks the wisdom which makes life sacred and meaningful. The challenge for today's mental health system is to unite East and West; to integrate wisdom and science; to make room for the sacred as well as the practical. One of the most critical domains for integration – and one of the most difficult to address – is the area of religion and spirituality. The purpose of this paper is to review the historical tension concerning the integration of religion and the science of mental health; to explore current social trends that are creating new opportunities and pressures to move in this direction; and to discuss strategies for the integration of religion and spirituality in mental health services and practice.

Religion and spirituality have very different connotations for most readers. Following Zlatka et al (2007) and others, this paper will use *religion* to refer to an organized system of beliefs and rituals associated with an institutional structure, and *spirituality* to refer to a personal quest or connection to the divine that can occur either within or outside formal religion. While overlapping, the distinction between these two concepts can be important, especially from an experiential basis.

Historical Perspective on Integrating Science and Religion

Over a hundred years ago, William James published *The Varieties of Religious Experience*, a book that was influential in its time and is still widely read today. Often considered to be the father of American psychology, James believed that religious experiences - like all other forms of experience - can and should be studied empirically. He presented examples of a wide variety of religious and spiritual phenomenon, including faith, conversion, saintliness, and mysticism, and discussed both positive and negative religious states.

James argued persuasively that the value of a religious experience rests in the individual's subjective evaluation of its effect, regardless of establishing a "naturalistic or a deistic explanation." In other words, if a spiritual experience has consequences – if it makes a person feel happy or be more productive or if it "proves to be a force that he can live by" – then it really doesn't matter if God exists or if the experience can ultimately be explained by neurochemistry. James also pointed out that many spiritual experiences are "absolutely authoritative over the individuals to whom they come." Although from a rationalist perspective these experiences might seem illusory, people who have had them

are convinced that they are real, and it is "vain for rationalism to grumble about this." James acknowledged widespread opposition to including religion as a serious subject for scientific study, but countered that spiritual experiences - whatever you think or believe about them – are an important part of human existence, and as such, demand empirical investigation.

A century later, the same discomfort about mixing science and religion continues to paralyze the field. Religion and faith receive increasing attention in the mainstream media, and even a cursory review of the psychology and religion section of any bookstore shows that public interest in these issues is growing at an astounding pace. At the same time, it is difficult for a serious scientist today to explore matters of faith or religion without risk of being accused of "little more than magical thinking"(Dean, 2006). The natural reluctance of scientists to delve into the realm of spirit is exacerbated by the current political climate where matters of faith are highly politicized and where religion and science are at times lined up in direct opposition. Little wonder that progress is slow.

However, there is mounting evidence that western culture is undergoing a significant shift from a strictly materialist, positivist and empiricist view towards a naturalistic understanding that acknowledges the significance of personal stories, emotions and experiences that cannot be explained purely in terms of science (Cullilford, 2002). Such a radical social transformation would clearly open the door for better integration of science and religion. In the past decade, there has been substantial progress towards serious consideration of religion in overall health care (Koenig et al, 2001). Since 1990, almost 1500 research studies, reviews, articles and clinical trials have been published on the connection of spirituality or religion to medicine and health – a figure equal to the total of all such pieces published prior to 1990 (Benson, 2001). Research groups such as the Fetzer Institute and the Center for the Study of Science and Religion at Columbia University are bringing spiritual issues and states of consciousness into mainstream research (see http://www.fetzer.org; http://www.columbia.edu/cu/cssr). Similarly, in mental health, systematic and rigorous study of spiritual states of consciousness began in the 1950's and 1960's, when Abraham Maslow, Stanislav Grof, Viktor Frankl and others established the field of "transpersonal psychology," and has continued with the seminal work of Ken Wilber and others (Wilber, 1980). The past few years have seen a rapid expansion of the field to include research on the beneficial impacts of meditation, chanting, prayer, and a whole range of religious beliefs and practices (Shorto, 1999).

Advances have also occurred in the integration of religion into clinical practice. Since the 1970's, a small but determined group of mental health professionals have worked to bring religion into professional discourse and programs and to introduce cultural perspectives on religion into clinical training (Kehoe, 1999; Shorto, 1999). In part due to their efforts, psychiatry has formally endorsed a "bio-psycho-social-spiritual model," and includes a category of "religious or spiritual problem" in the DSM-IV (Turner et al, 1995). The Joint Commission on the Accreditation of Healthcare Organizations now requires that a spiritual assessment be conducted with mental health and substance abuse patients (JCAHO, 2005), and several screening tools exist. However, the DSM-IV inclusion is largely symbolic, and many professionals, concerned about ethical

quandaries and boundary issues raised by assessing spiritual needs, are wary about moving in this direction (Post, Puchalski, and Larson, 2000).

A few pioneers have also worked diligently to explore the relationship between spiritual states and psychosis, making important inroads in understanding the similarities and the critical distinctions between the two states (Shorto, 1999; Nelson, 1994). However, despite these pioneering efforts, serious consideration of the role of spirituality and religion in the lives of people with psychiatric disabilities remains scarce, and professionals who work in this arena remain on the margins of the field. The volume edited by Roger Fallot almost a decade ago (Fallot,1998) remains one of the few resources on religion or spirituality targeted at mainstream public mental health and psychiatric rehabilitation programs.

While progress within the public mental health field has been slow, significant advances are being made in our understanding of the biological substrata of altered states of consciousness and in the integration of eastern and western medicine. Innovations in both scientific theory and research suggest that it is quite possible to use scientific methods to explore transcendent phenomena, and new conversations between science and religion are occuring. Emerging findings in the neurochemistry of alternative states open the door to thinking about consciousness as a multidimensional phenomenon (Nelson, 1994). Other research spans traditional boundaries between biology and religion. For example, recent studies of the biology of forgiveness (a traditional religious concern) suggests that resolving religious issues may have a measurable impact on brain chemistry (Dayton, 2003; Halter, 2005; Sevrens, 2000.) Recognizing that a substantial number of people who have never received a psychiatric diagnosis report altered states of consciousness may also help to "normalize" the experiences reported by clients. For example, 25% of the general population report having had out-of-body experiences (Nelson, 1994). For the practitioner, familiarity with these facts may make it easier to integrate discussion of religious and spiritual experiences with scientific assumptions about the basis of behavior.

Theoretical advances in the integration of eastern and western medicine also provide a potential bridge. New discoveries in quantum physics (e.g., Blood, 2001) suggest that consciousness can be understood in terms of energy and vibration as well as anatomy and chemistry. Traditional Oriental medicine rests on an ancient and sophisticated theory of life energy or "prana" flowing through meridians throughout the body, with seven "chakras" controlling the manifestation of prana in consciousness and behavior. Considering altered states of consciousness - including psychosis - from this framework can be very useful. Nelson (1994) suggests that the chakra system is actually tapping into the quantum level, and provides a comprehensive system for categorizing altered states according to the chakra on which an individual is focused. Acknowledging energy and vibration as a legitimate substrate for consciousness also opens the door for understanding the impact of music, chanting, mantra yoga, and other techniques that appear to intervene directly at the frequency/vibrational level (Nelson, 1994).

Current Social Context and Trends

Several social trends suggest that barriers between East and West, between religion and science will become more permeable in the near future. These trends include the recognition of religion as an imortant social institution, increasing cultural and religious diversity, and increasing interest in alternative medicine.

Increasing Recognition of Religion as a Social Institution. Organized religion and/or an inner sense of spirituality play a major role in the lives of the majority of Americans. According to The Pew Forum on Religion and Public Life, 87% of Americans view themselves as "religious," and 57% regularly attend a worship service. Americans attend religious services more than twice as often as Europeans, and in one study of fifteen nations, the United States had a religious membership rate twenty or more percentage points higher than every other nation except Northern Ireland (Curtis, Grabb, and Baer, 1992). There are over 300,000 religious congregations in the United States, making them the most common and widespread institution in the nation (Cnaan et al, 2004).

In the United States, people often turn to religious/spiritual institutions to seek meaning in their lives, for guidance and social support, to celebrate life's major events and transitions, and for assistance in times of trouble (Emerson and Woo, 2006). In fact, Americans are more likely to turn to clergy or to their congregation when they have serious problems than they are to turn to the government or to health and human service professionals (Cnaan et al, 2004). There is no reason to believe that people diagnosed with severe mental illnesses are any different in this regard (Fallot, 2007).

Moreover, while Americans are divided about the relationship between religion and morality (50% agree that belief in God is necessary to be a "moral person" and 47% disagree), they are openly critical of people who do not believe in God (atheists get a 34/54% favorable/unfavorable rating) and only modestly accepting of those who have no religious affiliation (people who are not religious get a 51/30% favorable/unfavorable rating) (Pew Forum on Religion and Public Life, March 20, 2002). Given this bias, and given the fact that people diagnosed with serious mental illnesses already struggle against widespread prejudice and discrimination, it would seem important to maintain or strengthen people's existing religious affiliations and support systems as part of their treatment or rehabilitation plan.

Increasing Cultural and Religious Diversity. While the United States has always been a nation of immigrants, recent patterns of immigration and refugee resettlement suggest that in the coming decades, cultural and religious diversity will have new and profound effects. Today's immigrants are largely *not* the most destitute, but those with at least a modicum of education and resources (Skerry, 2006). For many, full acculturation may not be essential in order to achieve financial or social success, and may not be their goal. Many recent immigrants from Africa, for example, intend to return home and/or choose to maintain "dynamic relationships" with their home countries (Zachary, 2006).   As a result, they may be reluctant to immerse themselves in English or to let go of their native culture. These new patterns of assimilation suggest that mental health practitioners will

increasingly be seeing clients who choose to view their mental health problems through a traditional (non-western) lens.

Today's immigrants are not settling just in big cities or in the four states traditionally known for their immigrant populations (California, New York, Texas and Florida.) Rather, secondary migration is leading increasingly to rural areas in the heartland, where immigrants can find entry level jobs in agriculture and in the food processing, meat packing, and casino gambling industries (Bloom, 2006). Pressures to accommodate cultural, religious and linguistic diversity are now virtually universal. Mental health practitioners will need to adjust, regardless of their geographical location.

The scope of cultural migration occurring today is staggering. No longer are cities split between two dominant ethnic or linguistic groups, as was common in the past. Rather, "mélange cities" are becoming the norm. For example, the "incredible polyglot blend" in the Washington, D.C. area includes more than 130 different countries (Ruble, 2006). In addition, the United States is also becoming more religiously diverse. Although a significant majority of Americans define themselves as Christian (76.5%), the percentage of the U.S. population identifying with other religious and spiritual traditions is increasing (World Christian Encyclopedia, 2001). Between 1990 and 2000, substantial increases were seen in the percentage of the population identifying as New Age (240%), Hindu (237%), Buddhist (170%), and Muslim (109%). The percentage of the population identifying as Christian showed a small increase (5%), and the percentage defining themselves as Jewish declined slightly (-10%). These statistics suggests that mental health practitioners need a new strategy for dealing with diversity. Quite clearly, it is not feasible to become conversant with hundreds of cultures and dozens of religions. Rather, to be relevant and effective, mental health practitioners need to reframe clinical and rehabilitation approaches to accommodate people's cultural and religious belief systems and to support people's innate wisdom. This is really no more than what has always been considered by the field to be sensitive and ethical practice.

Increasing Interest in Alternative Medicine. The application of cultural approaches to health care – known as "ethnomedicine" - is also expanding rapidly. Many culturally-based "alternative" treatments are now widely accepted as beneficial, including acupuncture, shamanic healing, massage therapy, Chinese herbal medicine and prayer and faith healing. An entire special issue of the *American Journal of Public Health* was devoted to the topic in August, 2002. For mental health practitioners, a basic level of familiarity with alternative cultural approaches is essential if their practice is to remain relevant. For example, American Indian communities have long embraced the influence of the spiritual. Within these communities, ritual, ceremony and spiritual interventions are now gaining legitimacy, although few non-Indians are prepared to provide these interventions (Cross, 2001). Similarly, the mental health system has begun to recognize the dangers of ignoring cultural and religious belief systems – the danger of misdiagnosis or inappropriate interventions (e.g., allegations of child abuse resulting from surface bruising caused by "coin rubbing to let out the bad elements" in Vietnamese traditions); the danger of interfering with natural healing processes (e.g., medications that suppress dreams or voices of spirits or ancestors through which healing is seen to happen in

aboriginal cultures); or the loss of potential healing opportunities through dismissing potentially effective rituals that appear bizarre to the western mind. For example, there is evidence that psychiatric patients improve after undergoing a firewalking ritual in Malaysia (Jopson, 2001).

Research data increasingly support the effectiveness of religiously-based mental health treatments. In one study, Hindu laborers with diagnoses of paranoid schizophrenia, delusional disorders, and bipolar disorders that had lasted, on average, for a year, were "treated" by Hindu temple supervisors who encouraged them to participate in daily chores and religious rituals. They were given no medication or western therapy. After several weeks of "residential treatment" at the temple, they showed improvement rates comparable to those of western medicine (Raguram et al, 2002). In more familiar western cultural contexts, faith and prayer are increasingly being accepted as effective mental health treatments, even for people diagnosed with severe mental illnesses (see review in Fallot, 2007).

While the thought of incorporating this variety of approaches into clinical practice is daunting, what is needed is not so much to learn *about* other cultures and other religious systems, but to learn *from* them. To do so may require a suspension of belief and an attitude of being a student rather than a teacher. But approaching each culture and each religious or spiritual tradition with respect creates the possibility for a real healing connection to be established.

Spirituality, Religion, and Recovery

For the past fifteen years, the mental health system has been struggling to become "recovery-oriented." While there are many definitions of recovery, most emphasize self-determination, choice, and "self-defined needs" (National Coalition of Mental Health Consumer/Survivor Organizations, 2006). Others stress that recovery "requires reframing the treatment enterprise from the professional's perspective to the person's perspective." Few dispute the goal, but many challenge how effective current reform efforts have been (Davidson et al, 2006). Mental health consumer/survivors, in particular, complain that the concept of recovery has been "co-opted" and that changes have been superficial at best. It seems to many that the intoxicating goal of recovery is most often translated into "more of the same (maybe slightly improved) services." Introducing a spiritual framework could open the door to a new and deeper vision of recovery – one that has long been espoused by consumer/survivors.

The Power of Adopting a Spiritual Framework. In his landmark book, Russell Shorto (1999) points out that more than any others, people with severe disabilities - whose lives are largely controlled by mental institutions and professionals - have had religion systematically denied to them. Shorto comments that "Psychologists are only now beginning to understand how devastating this whitewashing of religion has been." A few courageous clinicians and consumer/survivors have been working for change, and some advocacy organizations have started to get involved (NAMI's "Faith-Net" is a notable example) but the situation remains basically unchanged.

Mental health consumer/survivors have been exploring spiritually-based approaches to mental health for decades, and have repeatedly asserted that to have any real meaning, the "recovery paradigm" must go beyond traditional conceptual frameworks. Sally Clay (1994, 1996) has written eloquently about the application of Buddhism to the recovery process. Ed Knight has reminded the field about the spiritual basis of addiction and mental health recovery (Laudet et al, 2000; Knight et al, 2006). Dan Fisher and Pat Deegan have introduced spiritual wisdom to our understanding of recovery and to clinical training (Blanch, Fisher et al, 1993; Deegan, 2001, 2006). Many others have described their personal spiritual journeys to help convey the more ineffable aspects of recovery (e.g., Bassman, 2001; Leibrich, 2001). Consumer/survivors have traditionally shared their wisdom through informal communications – workshops, unpublished manuscripts, websites, personal communications, and blogs. Stories of recovery, coping strategies, and referrals to self-help groups and spiritual counseling are easily accessed through personal websites (e.g., sallyclay.net) and organizational resources (e.g., realization.org; spiritualemergence.net, verrazanofoundation.org/spirit, spiritualrecoveries.blogspot.com).

Consumer/survivors emphasize the power of adopting a spiritual explanation for their experiences and the satisfaction of affiliating with a spiritual community of choice. They also describe concrete practices that, while not empirically tested, have helped in their personal recovery. Most importantly, they emphasize that a psychiatric diagnosis does not affect the deepest drives of humanity – to live with purpose and to become a decent human being. Understanding one's problems in religious or spiritual terms can be an extremely powerful alternative to a biological or psychological framework. "Serious mental illness" – even when viewed through the most optimistic recovery framework – is usually perceived as a gloomy diagnosis. Many clients believe that it means they will never be fully well, that the best they can hope for is to keep their symptoms under control and to live as "normal" a life as possible. The hard work of recovery may be seen as boring and tedious, requiring them to forego much of the fun and spontaneity of life.

If the experience is framed in spiritual terms, on the other hand, the end result of all the pain and hard work may be envisioned as spiritual development - a worthy if difficult goal. Although reframing the issue in this manner may not change the reality of the situation, having a higher purpose may make a huge difference in an individual's willingness to bear pain, work hard, and make sacrifices. Other aspects of a spiritual frame may also be deeply consoling. If an individual believes that their soul has come onto the planet with "impressions" or memories from a past life, the recovery process may be conceptualized as healing not only the self, but helping to heal the collective consciousness of the planet. Experiences of abuse or trauma might be viewed as having occurred in past lives and as important lessons to be learned from and healed or responded to differently in this lifetime. Some spiritual traditions work directly on this premise. Again, serving a purpose beyond one's self may provide meaning to the experience which can make it possible to live with what might otherwise be unbearable. In addition, for people of deep faith, a spiritual explanation may simply *feel* correct, and may therefore eliminate tension around finding the right diagnosis or the right explanatory model.

It is also important to recognize that people who have struggled with serious psychiatric disabilities have often faced challenges and disappointments that are unimaginable to most of us. Some have mastered difficult spiritual lessons – patience, serenity, humility, non-materialism – that the rest of the world is still working on. If the mental health system were to take seriously the goal of meeting clients in a spiritual space, it is likely that they would have as much to teach as to learn.

Challenges in Adopting a Spiritual Framework. Adopting a spiritual approach to treatment and/or recovery requires both an openness to new information and considerable courage to confront prevailing norms. Modern society is based on the fundamental premise that the material world is "real" and the non-material world illusory, at best a by-product of the material. To willingly engage in the non-material runs counter to everything we are taught. This may be a very significant challenge for practitioners and clients alike. People who are on a spiritual or a mystical path may hold any of a number of beliefs that can easily appear "insane" when viewed through a materialistic lens. For example, many people believe that:
- The soul is a more important vehicle for healing than the mind or psyche.
- Problems may stem from experiences that occurred before conception.
- There is continuity after death. Assistance can come from people who are no longer alive.
- There are beings who exist in other dimensions who can assist in healing.
- The purpose of life is to prepare for what happens after death.
- What happens now can affect the past as well as the future.
- There is only one being, we are all interconnected parts of that being.
- All healing occurs through prayer or through the grace of God.

People may also have a variety of experiences that cannot be explained rationally, including voices and visions; unusual sounds or smells; seeing lights or auras; experiences of energy, from subtle releases to extreme electrical charges; abrupt involuntary changes in breath; states of bliss, terror, or other extreme emotions; feeling of merging into oneness; out-of-body experiences; temporary paralysis; depersonalization and trance states; and precognition, telepathy or other forms of extrasensory perception. These experiences – or experiences that look a lot like them - are common to people in psychotic states , people who have experienced severe trauma, and people on a mystical path (Nelson, 1994). They cannot be taken in isolation as evidence of mental illness – although in a mental health setting, they commonly are.

Practitioners may be wary of "glorifying" what they view as mental illness (despite established correlations with positive characteristics such as creativity, eg, Andreason, 1987), or implying that all altered states are pathways to spiritual bliss and that mental illness is a "myth." On the other hand, it is clear that some altered states closely resemble psychosis but have different etiologies and consequences. Erring in either direction can have profound results (Washburn, in Nelson, 1994). However, substantial progress has been made in distinguishing true spiritual encounters and benign altered states of consciousness from more harmful and destructive psychoses (Nelson, 1994). All mental

health practitioners who see people in severe states need to be familiar with these distinctions.

Barriers and concerns about addressing religion and spirituality in a therapeutic setting have been discussed in depth elsewhere (Fallot, 2007). Practitioners are right to be aware that they are moving into emotionally volatile terrain. Some clients may have experienced harsh or punitive forms of religion in their childhood - sexual abuse by clergy is perhaps the most extreme example – that can have profound and lasting consequences on psychological development and faith life (Ganje-Fling and McCarthy, 1996; Sipe, 1995). Many client have experienced violence, abuse, and trauma from authority figures in their childhood, leading them to lose belief in a benevolent god. Many practitioners are concerned that addressing religion or spirituality may exacerbate psychosis by supporting delusional thinking or encouraging mind-altering practices, or that clients may choose alternatives in lieu of potentially helpful treatments. It is true that some spiritual practices may create dissociated states, greatly heighten sensitivity, or cause dissolution of the ego – effects that may be contraindicated in some situations. (For example, there have been numerous caveats about the use of meditation). In addition, external controlling images of God may be retraumatizing for people with trauma histories. Some mental health clients may also be particularly vulnerable to charismatic, cult-like spiritual teachers and communities (Oakes, 1997; Singer, 1995). However, since clients often use these techniques and make these connections on their own, bringing them into the therapeutic conversation is likely to be more helpful than harmful. Moreover, as research and experience grows, guidelines are being developed to assist clinicians in making important distinctions (see, for example, the Spiritual Competency Resource Center, www.internetguides.com).

Both clients and practitioners are likely to vary widely in the degree of comfort they have in discussing religion. It may be a challenge for practitioners to examine their own religious belief systems and to understand the potential implications for their professional practice. For some, it will be a stretch even to raise the issue - to discuss religious beliefs or concerns may feel like dangerous territory, especially for atheists or agnostics Those who have a deep personal religious faith may find it difficult to put their own beliefs aside to accommodate a different belief system, or, on the other hand, may be wary about "proselytizing." Others will find it easy to discuss religious or spiritual issues, but will continue to frame the encounter in traditional terms - as a therapeutic, clinical or rehabilitative enterprise made more culturally relevant and perhaps marginally more effective by introducing religion or spirituality. At the other end of the continuum, some practitioners and clients – the mystics among us – may believe wholeheartedly that all healing is a spiritual endeavor, and that the goal of an integrated mental health approach is to weave therapeutic insights into what is essentially a spiritual process. Finding an appropriate frame for the conversation, one that respects both client and practitioner, is essential. There are thorny ethical and professional issues to work out, and very few professional forums in which to do so.

Suggested Strategies for Integrating Spirituality in Mental Health Practice

The historical and social trends described in this paper are fundamental in nature, and their implications are profound. To respond adequately will require more than just widening our clinical lens to include new viewpoints and new possibilities or about including spiritual or religious topics as a standard part of mental health programming. Both of these shifts are essential. However, the magnitude of the changes reviewed here suggests that the basic clinical paradigm needs to shift from *having a set of solutions and tools* to *asking questions and supporting the wisdom inherent in the client's support system*. This approach would be a natural extension of the psychiatric rehabilitation process as it has evolved over the past thirty years (Anthony, 2004), and would include 1) information gathering as the most critical part of assessment, 2) a formal acknowledgement of and accommodation to the client's preferred explanatory framework, 3) an expanded consultative model, and 4) the development and implementation of a set of interventions drawn from the experience of clients as well as practitioners.

Spiritual Information Gathering. During assessment, attention would be focused first *not* on making a diagnosis or setting a rehabilitation goal, but on gathering information about the client's experiences – including their religious and spiritual beliefs, practices, aspirations, and community, as well as any past experiences, either positive or negative, that could affect their psychological and spiritual lives The goal would be to learn as much as possible about healing and mental health from the religious or spiritual viewpoint held by the client. The critical skills for the practitioner in this phase would be first, to have the courage to address "taboo" topics (including such uncomfortable topics as sexual abuse), and second, to *not react* to beliefs or experiences that may appear bizarre. Since many mental health practitioners have been trained to look specifically for what is wrong with the patient and to act quickly if there are signs of psychosis, this may require "un-learning" some well-established habits.

Acknowledging the Client's Explanatory Framework. A second, and even more challenging step would be a formal acknowledgement of the client's explanatory framework and an active attempt to accommodate to that framework. It is *not* necessary to completely abandon one's present conceptual model, only to accept that other explanatory approaches might also be legitimate. Analyzing the situation in the manner preferred by the client has many benefits. Most obviously, it builds rapport and trust, and working from the client's frame of reference has been shown to increase adherence to treatment plans (Eisthenthal et al, 1979). Most clinicians have experience in integrating more than one treatment modality in therapeutic situations – using psychodynamic principles within a cognitive-behavioral approach, integrating sensory-based therapies with counseling, or using medication alongside rehabilitation or trauma-specific treatment. The added challenge here is to create an effective integration of the client and the practitioner's belief systems. To the extent that this can be accomplished, and therapeutic interventions can be based on premises endorsed by both parties, the power of belief can be intentionally harnessed to support the chosen interventions.

Expanded Consultative Model. Since (outside of their own belief system) religion and spirituality are unfamiliar terrain for the average mental health practitioner, it will be necessary to reach out to clergy, spiritual teachers, and/or others who hold cultural wisdom – a consultative model that goes significantly beyond standard practice.   In order to do this, practitioners will need to understand some basic definitions and distinctions.

Most if not all religions include theological and ethical dimensions, which provide a framework for understanding the divine and for leading a good life. In addition, most include a mystical tradition, with specific teaching and practices designed to induce a direct experience of the divine and to develop spiritual skills such as strengthening will, controlling ego, and developing mastery. The kabbalah in Judaism, yoga in Hinduism, sufism in Islam, tantra in Buddhism, and the contemplative traditions in Christianity are examples. Originally, mystical teachings were kept secret or were shared only with an inner circle of people, in part as an acknowledgement of their power to affect consciousness and the need to protect and guide students. Many had explicit rules about who could and could not enter training. (The kabbalah, for example, was limited to people over a certain age.) To complicate the situation, there were often schisms between the organized religious hierarchy and those who followed the esoteric or mystical path. Today, mystical practices (e.g., yoga, meditation) are increasingly being taught by practitioners outside a religious context, and many of the original cautions about their use have been abandoned. Since mystical practices have direct effects on consciousness, they (much more than theology or ethics) have the potential for both positive and negative effects on mental health. As more and more people experiment with mystical paths and practices, it will become increasingly important to understand these distinctions.

Theological and ethical issues that might be brought to the mental health setting include questions about scripture (What does the Torah or the Koran say about problems like mine?), morality (What in my behavior constitutes sin?), meaning (How can I believe in a God that will allow such terrible things to happen?), faith communities (finding a religious community that will provide unconditional support), religious practices (difficulty in praying or in observing a required ritual), desire to convert to a new faith or join a religious group, and so forth. Questions of this nature are closely related to the key issues facing people diagnosed with severe mental illnesses – discrimination, loss, anger, impaired concentration, childhood trauma, etc – and in some cases, simply providing a forum for airing concerns may be enough.

However, some questions may be better referred to a religious leader or teacher. The mental health practitioner's responsibility in this case is to be familiar with the range of religious traditions in the local community and the possibilities for referral. Distinctions between different traditions within a religion may be extremely important (e.g., between Orthodox and reformed Judaism, Sunni and Shia Muslims, Evangelical Christians and other Protestants, Zen and Tibetan Buddhism, and so forth). There is also great variability between individual religious personalities, and the right match is critical, so developing a pool of known referral possibilities is a good strategy. Resources are available for practitioners who want to begin building bridges with formal religious organizations and clergy. Several authors have written about the process of effective collaboration between

clergy and mental health professionals (Bilch et al, 2000; Day et al, 2005) and ways to bring religion and mental health into closer alignment (Loewenthal, 2000; Swinton, 2001), and a curriculum specifically designed for working with clergy has been developed and tested (Giller et al, 2007).

Using Spiritual and Mystical Practices to Assist with Recovery. Religious and spiritual traditions (especially mystical or "esoteric" paths) teach concrete techniques that affect specific aspects of consciousness. Such techniques include prayer and other tools for strengthening belief, purification rituals, self-observation, techniques to develop mastery over thoughts and behaviors, practices for minimizing or containing the ego and for controlling emotional excesses, structured processes for confronting the dark side of humanity and for overcoming fear of death; practices for developing and maintaining calmness in difficult situations, and so forth. In the past, information about these techniques was found only in historical religious texts, and instruction was available only through association with a teacher (sometimes requiring initiation into an esoteric school). More recently, attempts have been made to translate esoteric practices into terms that are understandable to laypeople. While a review of this literature is obviously beyond the scope of this paper, noteworthy examples include attempts to describe the healing aspects of traditional mystical practices in modern terms (e.g., Chisti, 1985), clinical interventions that cross-walk new discoveries in physics and neurology with ancient spiritual wisdom (e.g., Childre and Martin, 1999; Dacher, 1991; Pearsall, 1998), and of course, a growing body of popular literature on spirituality and healing (e.g., Chopra, 1995). There is even a much-used "how-to" guide for teaching meditation and other spiritual techniques to people in institutional settings (Lozoff, 1985).

Only a few of the techniques and practices that come from traditional wisdom sources (or from newer explorations in consciousness studies) have been empirically tested. Practitioners will therefore need to be particularly careful to follow the client's direction, learn as much as possible about the practice, talk with others who have used it, and meticulously observe and record the impact over time.

Conclusion. Like the one-eyed giant described by Merton, the mental health system has a limited perspective on reality, and like the one-eyed giant, it has gained so much power from its grounding in a scientific model that it has become almost impossible to challenge. This paper has suggested that what the mental health system lacks most – and what may actually hold the key to a real recovery paradigm – is to open the other eye to the wisdom that comes from other sources – from cultural and religious systems of thought and from inner spiritual knowing. Topics that have historically been silenced may hold the very keys to the next steps in recovery. Cultural trends suggest that more and more people will be trying to look with both eyes. Emerging science indicates that there is something worth seeing. And thousands of years of wisdom traditions suggest that mental health consumers stand to benefit.

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