Spirituality is typically related to religious ideologies, and often one’s religious beliefs are intertwined with one’s spiritual beliefs. However, spirituality and religion are actually two separate constructs, with spirituality coming from within an individual and religion being the means for the individual to express their spirituality (Hodge, 2003). For the purpose of this paper, spirituality will include an individual’s personal relationship with a higher being, as well as the effect of the individual’s utilization of socially constructed religious institutions. As is the case with many theories, there are both positive and negative effects of an individual’s spirituality on their mental health. These effects will first be discussed in general, and later specific to each disorder that is presented. Discussion will include positive and negative factors, the necessity of an instrument that measures an individual’s internal spirituality separate from any religious connotations, suggestions to the clinician on how best to incorporate the patients’ spirituality into their assessments, the effect of the individual’s spirituality in the case of specific disorders (e.g., severe depression, post-traumatic stress disorder, and schizophrenia), and an example of a spiritual theoretical framework for treatment.

There are many positive factors involved in utilizing one’s spirituality as a coping mechanism. The religious aspect gives the individual access to a support system, which includes a sense of fellowship and belonging. The organized rituals that are at the center of many religions lend a sense of security and continuity to those who feel a lack of control in other aspects of their lives. The spiritual relationship between the individual and the higher being may contribute to their ability to derive meaning for life events, offer them hope in the face of adversity, and provide them with a feeling of nonjudgmental acceptance. Many individuals have a perception of a benevolent higher being that loves them regardless of their flaws, forgives them for their sins, and has control over life’s circumstances (i.e., knowing the outcome of events). This higher being has the individual’s best interests in mind, and provides purpose to the events that take place, good or bad, in their lives.

Research suggests that an individual’s particular style of relating with their higher being may predict how useful their spirituality is as a coping mechanism. (Yangarber-Hicks, 2004) Pargament and colleagues (1990) (as cited by Yangarber-Hicks, 2004) identified three major religious coping styles: self-directing, deferring, and collaborative. A fourth style was added by Pargament and colleagues (1990) which they termed plead. The collaborative approach involves joint responsibility for problem solving by God and the individual, the self-directing style places all of the responsibility for problem solving on the individual to the exclusion of reliance on the higher being, the deferring style places all of the responsibility on the higher being, and the plead style basically involves a tenant for wishful thinking. (Yangarber-Hicks, 2004) Research indicates that those who utilized a collaborative approach have a far better outcome in terms of their mental health than did those who employed the
other styles. (Yangarber-Hicks, 2004) Therefore, assessing an individuals’ spiritual relationship with a higher being is not all that is involved in the effectiveness of spirituality as a coping mechanism; one needs to assess the type of relationship that the individual has with his/her higher being.

These different approaches that the individual may have to his/her spirituality or relationship with a higher being are where one may find some negative effects. For those who experience spiritual struggles when dealing with adversity, their relationship with a higher being may cause them extreme distress and prove detrimental to their mental health. Life stressors, such as loss of income, loss of a loved one, loss of one’s health, natural calamities, among others, may cause an individual to question his/her relationship with his/her higher being, and may be the catalyst for spiritual struggles to ensue. These spiritual struggles are the result of, “...conflict, question, and doubt regarding matters of faith, God, and religious relationships,” (McConnell, Pargament, Ellison, & Flannelly, 2006, p. 1470) and can be separated into three categories: interpersonal, intrapersonal and divine. Interpersonal struggles would involve spiritual conflict between the individual and others, intrapersonal struggles would involve the individual’s inner spiritual conflict, and divine struggles would involve conflict between the individual and his/her higher being (McConnell, Pargament, Ellison, & Flannelly, 2006). These spiritual struggles may result in an increase in stress and anxiety, or even depression, which may create an additional risk for mental illness.

Another component to the negative effects may be seen in the relationship between the individual and their religious ideologies. Some denominations of the Christian faith follow very strict guidelines in regards to lifestyle choices, such as sexual orientation, marital status, and procreation. These guidelines are often considered to be prominent features of an individual’s acceptance into the religious community, as well as admittance into the afterlife, which is his/her ultimate goal. Individuals who belong to such denominations are faced with the conflict of choosing between their faith and their own sense of individuality. This conflict may be the source of much stress and confusion, which may ultimately be the cause of their mental anguish. An instrument for assessment should include spiritual struggles, due to the research findings that show that, “…interventions targeting spiritual struggles may help reduce and prevent psychological distress and psychopathology in individuals facing stressful experiences.” (McConnell, Pargament, Ellison, & Flannelly, 2006, p. 1480)

The research mentioned above indicates that spirituality may play a part in helping individuals cope with life stressors, but the focus of this paper is to demonstrate the efficacy of spirituality for patients suffering from mental illness. There have been numerous studies performed which suggest the viability of spirituality as a coping mechanism for those suffering from various types of mental illness, in regards to cessation or easing of symptoms, adherence to treatment, and overall adjustment and ability to function in society. Severe depression is one such illness. Individuals who suffer from severe depression describe their illness as creating a sense of disconnection from their higher being and of experiencing a deep yearning for a sense of meaning. (Sorajjakool, Aja, Chilson, & Johnny Ramirez-Johnson, 2008) Fifteen individuals who had been diagnosed with depression were interviewed by researchers in order to determine the role of spirituality in their lives. The results demonstrated that
the participants desired to regain their relationship with a higher being that they had lost due to their depressive symptoms. All fifteen stated that spirituality remained one of their coping methods, enabling them to withstand the desire to commit suicide, giving them hope, comfort, and sustenance during the dark and cold periods of their lives (Sorajjakool, Aja, Chilson, & Johnny Ramirez-Johnson, 2008). Another benefit of spirituality for this population was the ability to find meaning from their depression. For example, “...individuals with depression have an intense desire to make sense of their experience with depression.” (Sorajjakool, Aja, Chilson, & Johnny Ramirez-Johnson, 2008, p. 527) If these patients are able to come to terms with their illness and to assign meaning to it, then they are more likely to seek treatment and to have a higher degree of compliance to their treatment (Sorajjakool, Aja, Chilson, & Johnny Ramirez-Johnson, 2008).

Schizophrenic patients are another population to whom research has demonstrated a high prevalence of spirituality and religiosity:

When other sources of support are lacking, spiritual support makes explanations possible when no other explanations seem convincing, brings a sense of control through the sacred when life seems out of control, and provides new objects of significance when old ones are no longer compelling. These factors may contribute to the high prevalence of religious coping in schizophrenia, a disorder associated with impairment in multiple domains of functioning that often remains chronic and disabling. (Mohr, Brandt, Borras, & Christiane Gillieron, 2006, p. 1958)

According to Mohr and colleagues, (2006), out of 115 patients diagnosed with schizophrenia, 71% stated that they used religion as a positive way of coping. Further, they cited many of the same benefits as the patients suffering from severe depression: hope, comfort, meaning of life, among others. While schizophrenic patients have a different set of symptoms than the depressive patients, such as delusions and hallucinations, the majority of these subjects stated their spirituality helped them to cope with their condition.

In contrast to the benefits described above, negative aspects of spirituality are reported by 14% of participants, many of which originated with their religious ideologies. As mentioned previously, there are those for whom religion has different meanings and for whom faith in a higher being involves belief that their higher being will take care of their problems without any effort on their part. This was the issue for the individuals in this study who did not find spirituality to be helpful. This information would be helpful for the clinician in order promote understanding of their patients.

With regards to patients suffering from post-traumatic stress disorder and spiritual beliefs, studies involving military personnel who have been involved in combat situations have reported experiencing a loss of meaning and being burdened with a sense of guilt, was associated with weakening of their religious faith (Fontana & Rosenheck, 2004). This inner turmoil may have a significant effect on the ability of these patients to recover. Resolving these inner conflicts may contribute to the patients’ recovery. Clinicians should have access to these individuals’ spiritual conflicts, and therefore, the integration of spirituality in the assessment process is highly recommended.

Spirituality may play a central role in the coping styles of patients who suffer from bipolar disorder. Mitchell and Romans (2003), report that 94% of individuals who
had been diagnosed with bipolar disorder affirmed that they had some sort of religious or spiritual beliefs and that they utilized those beliefs to help them cope with their illness. An interesting aspect of this study was the participants’ experiencing of conflict between the advice of their spiritual advisors and their health professionals, which caused a lack of compliance (Mitchell & Romans, 2003). The problem apparently arises in the form of differing illness paradigms between the health care professionals and spiritual advisors. The respondents in this study were an indigenous people who have a holistic approach to health, which involves the body, mind and soul, while the health care professional’s approach is of a reductionist biomedical nature (Mitchell & Romans, 2003). The authors suggest a need for mental health care professionals to address their patients’ spiritual beliefs in order to have a better understanding of what may motivate them to adhere to treatment.

The preceding studies demonstrate support for the efficacy of utilizing the individual’s spirituality as a coping mechanism in the case of mental illness, which in turn suggests the need for an instrument to assess the individual’s spirituality. Assessment of spirituality has typically been performed with the use of a number of instruments throughout the years, but these instruments are more accurately described as measures of religiosity, with many of the questions pertaining to such factors as church attendance. The need for an instrument that will be a more accurate measure of an individual’s spirituality has come to the attention of researchers and several have been developed, but there are at least two limitations of these instruments: one is that they mention “God” and the other is that they are not based upon previous research. (Hodge, 2003) These are important criticisms as not all individuals come from the Judeo-Christian population and therefore, do not perceive of a higher being termed “God” nor do they belong to a particular religious organization. Secondly, the failure to build upon previous research demonstrates a lack of concern for the scientific method. Hodge (2003) has developed a six-item instrument based upon Allport and Ross’ (1967) measure of intrinsic religious orientation, which he suggests is a viable option due to the fact that it has been used in many settings and has good validity. The fact that Hodges’ (2003) instrument is based upon a measure of intrinsic religion is interesting, since it represents the internal aspect of a relationship with a higher being, which has been termed previously in this paper as spirituality.

Hodge (2003) specifies a six-item scale, The Intrinsic Spirituality Scale, which utilizes the phrase completion method with the Likert response keys. He states that, “...this new measure of intrinsic spirituality taps the degree to which spirituality is salient in an individual’s life as a motivating influence.” (Hodge, 2003, p. 55) This instrument demonstrated good validity due to the high degree of correlation between it and the established Allport and Ross’ (1967) measure. This would be an accurate measure of the individuals’ spirituality and as such a good assessment tool for the clinician to incorporate into their practice, dependent upon the manner of mental illness one’s patients present with.

The need for a viable instrument to assess the patients’ spirituality is only one part of the equation; one has to factor in the clinicians’ approach to spirituality. A clinician needs to remain unbiased and nonjudgmental during the therapeutic process and therefore, must have an awareness of their own feelings regarding spirituality and religion. A therapist with a specific religious orientation or with specific ideologies may ascribe their beliefs onto the patient without having any conscious knowledge of doing so (Pargament, 1997).
According to Pargament (1997), there are several orientations that a clinician may have, four of which are: religious rejectionism, religious exclusivism, religious constructivism, and religious pluralism. The rejectionist is one who shows a complete disdain for religion as seen in the examples of such historical pioneers in psychology as Freud and Albert Ellis. Pargament (1997) discusses several flaws with this orientation: it dismisses an entire population of patients, it does not take into account recent research, and it is unethical according to recent ethical professional guidelines as set forth by the “Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations.” (APA as cited by Pargament, 1997) The exclusivist takes the opposing view of the rejectionist, in that they suggest that religion is at the heart of all problems. This orientation shares several flaws with rejectionism: it limits the clinician’s population of patients, except that it lies in the direction of those patients who do not hold similar beliefs; it poses ethical concerns in terms of imposing one’s religious ideologies on one’s patients; it disregards current research which demonstrates that there is a multitude of forms of spirituality (Pargament, 1997).

The last two orientations that Pargament (1997) presents at first seem to be very similar in regards to how they approach the individual’s beliefs: they both attempt to see the individuals’ perspective and work from within that framework, but the constructivist does not believe in the existence of a higher being, while the pluralist does. The constructivist acknowledges that religion or spirituality are constructs of the patient, has respect for those constructs, and attempts to help the individual find solutions that are consistent with their constructs (Pargament, 1997). This orientation allows for the acceptance of many diverse populations and is ethically sound, but Pargament (1997) suggests that there may be problems of authenticity with this approach, due to the manipulation of the patient’s beliefs without the foundation of any personal beliefs on the part of the clinician. This would not be an issue for the pluralist who has their own core beliefs. The pluralist appreciates the individual’s perspective and tries to work with them through their framework, but also holds their own beliefs. Pargament (1997) states “The pluralist facilitates the search for significance not through religious indifference on the one hand or religious zealotry on the other, but through a sharing of orientations” (p.371).

The efficacy of tapping into the individual’s spirituality and the need for an instrument to perform a spiritual assessment has been discussed, as well as some of the issues that may arise after determining the individual’s spiritual orientation and the part that it may play in their style of coping. If one decides to incorporate spirituality into the therapy sessions, the question arises of how one might proceed. Therefore, there is a need for a theoretical framework that will address spirituality as an intervention arises. A recent study has proposed just such a framework, and has implemented it on patients suffering from generalized anxiety disorder (GAD).

GAD is a chronic disorder that affects many individuals. The popular method of treatment is cognitive behavioral therapy (CBT), which has been shown to have very good results, but a current study has demonstrated that a spirituality based intervention (SBI) may be just as effective. (Koszyck, Raab, Aldosary, & Bradwejn, 2010) This study involved treating patients with a diagnosis of GAD using both SBI and CBT. The SBI focuses on spiritual well-being and growth, integrates core philosophies such as emotional and spiritual wisdom, spiritual awakening, positive emotions, ethical living, generosity, and service. (Koszyck, Raab,
Aldosary, & Bradwejn, 2010) The authors based their multifaith approach on seven religions (i.e., Buddhism, Christianity, Confucianism, Hinduism, Islam, Judaism, and Taoism) which allows clinicians to treat patients from varying religious and spiritual backgrounds (Koszyck, Raab, Aldosary, & Bradwejn, 2010). The results for the SBI showed significant reductions in symptoms, allowing for the introduction of SBI as an intervention for GAD. This information may be important for the clinician since, “many patients are requesting spiritually integrated care from mental health professionals.” (Koszyck, Raab, Aldosary, & Bradwejn, 2010)

In addition, a variation of SBI has been successfully used to treat patients with eating disorders (Smith, Hardman, Richards, and Fischer, 2003). The study involved assessing intrinsic religious devoutness and intrinsic religious affiliation. In addition, researchers examined improvements in spiritual well-being, by assessing prior to and upon completion of a treatment program. Specifically, the program consisted of patients participating in a biweekly, twelve-step group during which the patients were:

“...encouraged to explore their own spiritual beliefs and to draw upon their faith to assist in their recovery. It is felt that as patients align their behavior with their spiritual beliefs, they will benefit from improved confidence, self-respect, and peace of mind.” (Smith, Hardman, Richards, & Fischer, 2003)

The results of this study demonstrated a significant correlation between increased spiritual well-being and improvements in eating disorder symptoms. Further, there was also a significant correlation between increased spiritual well-being and improvement in psychological health, including body image (Smith, Hardman, Richards, & Fischer, 2003).

The positive and negative effects of spirituality as a coping mechanism have been discussed as well as studies demonstrating the efficacy of using spirituality as a coping mechanism with several mental disorders. Therefore, if one is willing to entertain the idea that spirituality may be beneficial for patients suffering from mental disorders, then there is support for the need of an assessment instrument to evaluate spirituality. Such an instrument has been suggested, as well as concerns for clinicians who desire to incorporate spirituality into the therapeutic session, including suggestions for a spiritual theoretical framework in which to base one’s approach.

It is also suggested that there is a need for more empirical research to determine the efficacy for the use of spiritual interventions with those who suffer from mental illness. If the findings of said research were to demonstrate support for spiritual interventions, then perhaps SBI may become an accepted paradigm for therapists, and be integrated into their practice.

There is a need for graduate programs to include awareness of spiritual orientations as part of their curriculum in the training of clinicians. There is much support from research and clinicians’ own experience for the implementation of spirituality in the field of psychotherapy, to the point of demonstrating the desirability of educating future clinicians in this area. According to Crook-Lyon and colleagues (2012), out of 340 psychologists surveyed, 65% stated that spiritual and religious issues should be included in graduate programs. The participants described themselves as psychologists, counselors, therapists and professors who work in the field of psychotherapy (Crook-Lyon, O'Grady, Smith, Jensen, Golightly, & Potkar, 2012). Although there was a consensus regarding

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the necessity of inclusion of spirituality and religion as part of the graduate curriculum, there was disagreement as to where these subjects may be added (Crook-Lyon, O'Grady, Smith, Jensen, Golightly, & Potkar, 2012). The authors suggested including spirituality and religion in multiculturalism coursework, due to the APA (2003) definition of multiculturalism: “multiculturalism, in an absolute sense, recognizes the broad scope of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation [italics added], and other cultural dimensions” (Crook-Lyon, O'Grady, Smith, Jensen, Golightly, & Potkar, 2012, p. 170). The results of Crook-Lyon and colleagues research demonstrated that 68% of clinicians agreed that multiculturalism would be an appropriate area of graduate studies to cover religion and spirituality, while others stated that including these subjects would cause other aspects of multiculturalism to receive less consideration (Crook-Lyon, O'Grady, Smith, Jensen, Golightly, & Potkar, 2012). Crook-Lyon and colleagues make a valid point which refers back to the discussion on SBI, and the necessity for clinicians to have a better understanding of those patients who entertain a holistic approach to illness: “....such a focus on client religion and spirituality in professional training would broaden clinicians’ holistic understanding of those with whom they work” (Crook-Lyon, O'Grady, Smith, Jensen, Golightly, & Potkar, 2012, p. 180)

Although an individual’s spirituality may be strongly associated with their religious orientation, there is strong support for the clinician to approach the individual from a spiritual standpoint, rather than a religious standpoint. This would allow for the inclusion of all forms of spiritual orientations, which would permit the clinician to treat a wide variety of patients from multiple backgrounds. The utilization of an instrument for assessment that is not biased toward any particular orientation, the demonstration of a pluralistic orientation which allows them to meet the individual at their personal spiritual level while maintaining their own spiritual identity, and a theoretical framework which encompasses a broad range of spiritual orientations is considered to be the best approach for the clinician.
References


