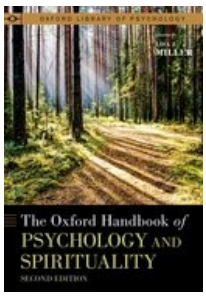

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CHAPTER

24 Spirituality and Recovery From Psychosis and Serious Mental Disorders

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Abstract

This chapter summarizes theory, research, and treatment regarding spirituality and recovery from psychotic disorders and severe mental disorders. The incorporation of spirituality into the recovery model was initiated by patients/consumers starting in the 1970s and has become widely accepted in the United States and around the world. Research shows the generally beneficial effects of spirituality on health, including mental health problems; surveys document the role that spiritual beliefs and practices play in many who are recovering from psychosis and severe disorders and the importance of religious coping for people facing serious mental health problems. Some successful therapeutic approaches for integrating spirituality into recovery are discussed.

Keywords: recovery, religion, spirituality, schizophrenia, bipolar disorder, coping, psychosis, severe mental disorders, schizoaffective, psychiatric survivor movement

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Introduction

The therapeutic value of spirituality in substance abuse treatment has been acknowledged for many years due to widespread recognition of 12-step programs, but this recognition is new in the treatment of psychosis and severe disorders such as bipolar disorder and schizophrenia. Spirituality is incorporated into treatment as part of the mental health recovery model, which has become widely accepted in the United States and around the world. In 1999, the U.S. Surgeon General in a landmark report urged that *all* mental health systems adopt the recovery model (U.S. Surgeon General, 1999).

What distinguishes the recovery model from prior approaches in the mental health field is the perspective that people can fully recover from even the most severe forms of mental disorders. Thus, services and research should be reoriented toward recovery from severe or long-term mental illnesses: recovery creates an orientation of hope rather than the "kiss of death" that diagnoses like schizophrenia once held. One hundred years ago, Emil Kraepelin named the disorder now known as schizophrenia "dementia praecox,"
p. 596 and ↳ considered it a chronic, unremitting, gradually deteriorating condition, with a progressive downhill course that ends in dementia and incompetence (Kraepelin, 1904). However, researchers in the past four decades have established that people diagnosed with schizophrenia, bipolar disorder, psychosis, and other serious mental disorders are capable of regaining significant roles in society and of managing their own lives. The Vermont State Hospital study, for example, showed that many long-term hospital patients previously considered "chronic" and "hopeless" did indeed move on to fulfilling lives (Harding et al., 1987) There is strong evidence that most persons do "recover," that is, enjoy lengthy periods of time free of psychotic symptoms, with some having those symptoms abate entirely, and can partake of community life as independent citizens. Daniel Fisher, hospitalized briefly with psychosis after taking LSD, now a psychiatrist and internationally recognized advocate for the recovery model, maintains:

> Believing you can recover is vital to recovery from mental illness. Recovery involves self-assessment and personal growth from a prior baseline, regardless of where that baseline was. Growth may take the overt form of skill development and resocialization, but it is essentially a spiritual revaluing of oneself, a gradually developed respect for one's own worth as a human being. Often when people are healing from an episode of mental disorder, their hopeful beliefs about the future are intertwined with their spiritual lives, including praying, reading sacred texts, attending devotional services, and following a spiritual practice.
>
> (Fisher, 2019)

Recovery vs. Medical Model

The medical model tends to define recovery in negative terms (symptoms and complaints that need to be eliminated, disorders that need to be cured or removed), and to emphasize the finality of diagnosis rather than growth and change in life experience. In the recovery approach, severity of impairment is not denied where it is present, nor is suffering romanticized, but resignation, hopelessness, and community exclusion are replaced by engagement, a hopeful attitude, and inclusion.

In the recovery model, health care professionals act as coaches helping to design a rehabilitation plan that supports the patient's efforts to achieve a series of functional goals. The focus is on motivating the patient's own efforts to help themselves. Respecting and supporting a patient's spiritual journey, as described later in this chapter, is often an important component of their recovery. Ridgeway provides this definition: "Recovery is an on-going journey of healing and transformation. It involves reclaiming hope and a positive sense of self despite the experience of psychiatric disability, self-managing one's life and mental health to reduce psychiatric symptoms and achieve higher levels of wellness, and reclaiming a life and roles beyond being a consumer in the mental health system" (Onken et al., 2002, p. 2). McAdams et al. (2001) conducted
p. 597 studies of people recovering from a range of adversities, and based on his findings and the extant ↳ literature concluded that successful recovery often depends on developing a positive sense of self:

> The take home message from the empirical literature on benefit-finding is that people who perceive benefits in adversity tend to show better recovery from and adjustment to the negative events that brought them into adversity in the first place … survivors of illness and trauma often

> report increased self-reliance and broader self-understanding, enhanced self-disclosure and emotional expressiveness in relationships and a changed philosophy of life.
>
> (p. 485)

These findings suggest that the process of recovery can occur even while the person continues to experience symptoms.

Importance of Spirituality in the Consumer Movement

The increasing adoption of the recovery model evolved from the growing movement throughout the United States and the world of people calling themselves consumers, service-users, survivors, or ex-patients. Having been diagnosed with mental disorders, they began working to challenge with health professionals to make changes in the mental health system and in society. The recognition of spirituality as an important component of recovery has been driven by these consumer and family grass-roots movements. In the late 1950s, with the advent of the civil rights movement, people began organizing to fight against inequality and social injustice. By 1970, the women's movement, gay rights movement, and disability rights movement had emerged. In this cultural context, in 1975, former patients in several cities across the country began what was first known as the psychiatric survivor movement with groups such as the Network Against Psychiatric Assault. The movement grew out of the idea that individuals who have experienced similar problems, life situations, or crises can effectively provide support to one another. Ex-mental patients organized protests, drop-in centers, artistic endeavors, and businesses.

Sally Clay, a pioneer of this movement and founder of the Portland Coalition for the Psychiatrically Labeled, wrote a seminal article in 1987 on spirituality and recovery that illustrated consumer concerns about the neglect of spirituality in their treatment. She has written about the important role that spiritual experiences played in her recovery following two years of hospitalization when she was diagnosed with schizophrenia at the Yale-affiliated Hartford Institute of Living (IOL). While hospitalized, she had a powerful spiritual experience that led her to attend religious services.

> My recovery had nothing to do with the talk therapy, the drugs, or the electroshock treatments I had received; more likely, it happened in spite of these things. My recovery did have something to do with the devotional services I had been attending. At the IOL I attended both Protestant and
p. 598 Catholic services, and if Jewish or Buddhist services had been ↳ available, I would have gone to them, too. I was cured instantly—healed if you will—as a direct result of a spiritual experience.
>
> (Clay, 1987, p. 91)

Many years later Clay went back to the IOL to review her case records and found herself described as having "decompensated with grandiose delusions with spiritual preoccupations" (Clay, 1987, p. 90). She complains that "not a single aspect of my spiritual experience at the IOL was recognized as legitimate; neither the spiritual difficulties nor the healing that occurred at the end" (p. 92). Clay is not denying that she suffered severe impairment at the time, but she makes the case that, in addition to the disabling effects she experienced as part of her psychosis, there was also a profound spiritual component that was ignored. She describes how the lack of sensitivity to the spiritual dimensions of her experience on the part of both mental health and religious professionals was detrimental to her recovery. Nevertheless, she has persevered in her belief that

> for me, becoming "mentally ill" was always a spiritual crisis, and finding a spiritual model of recovery was a question of life or death. Finally I could admit openly that my experiences were, and

> always had been, a spiritual journey—not sick, shameful, or evil.
>
> (Clay, 1994)

The consumer movement has maintained since its early days that recovery from psychosis is experienced by many as part of their spiritual journey. This was eloquently expressed by Jay Mahler, consumer advocate and program director of the Mental Health Division of Contra Costa County. During a conversation with Dan Weisburd, then editor of the CAMI's (California Alliance for the Mentally Ill) *The Journal*, Jay mentioned that he viewed his disorder as a spiritual journey. When Dan questioned how a devastating mental disorder could be a spiritual journey, Jay responded:

> Regardless of what anyone else chooses to call it, that's what it's been for me. The whole medical vocabulary puts us in the role of a "labeled" diagnosed victim.... But as they go through trial and error to control your symptoms, it doesn't take a genius to realize they haven't got the answers. No clue about cures! And oh boy, those side effects! I don't say medications can't help, or that treatments won't have value. But what I do say is that my being aware that I'm on a spiritual journey empowers me to deal with the big, human "spiritual" questions, like: "Why is this happening to me? Will I ever be the same again? Is there a place for me in this world? Can my experience of life be made livable? If I can't be cured can I be recovering... even somewhat? Has my God abandoned me?" Bottom line is ... we who have it have to wonder whether what remains constitutes a life worth living. That's my spiritual journey, that wondering. That's my search.
>
> (Weisburd, 1997, p. 2)

Starting in the 1970s, Jay Mahler and Frank Leonard organized spirituality groups in the San Francisco Bay
p. 599 Area. But it was in later conferences that consumers, mental health ↳ professionals, and religious professionals started holding dialogs and began networking to deal with the issue of addressing spirituality in recovery more effectively. Among the many events funded by National Institute of Mental Health was the 1993 Alternatives Conference, "A Celebration of Our Spirit" held in Columbus, Ohio.

The movement activism of the 1970s gave rise to a movement of consumers who are taking an active role in shaping the recovery model that is being widely adopted throughout the mental health system. A grass-roots network of family members of consumers also organized and founded the National Alliance for the Mentally Ill (NAMI) which includes their FaithNet network which conducts outreach and engagement of faith communities with mental health since 1998. NAMI's national conventions have featured many programs on spirituality, such as the 2006 NAMI Conference presentation on "Mental Illness as Spiritual Journey" by Rev. Susan Gregg-Schroeder as well as presentations by Jay Mahler and David Lukoff (Lukoff et al., 2009).

Pat Deegan, who is both a consumer and a psychologist, also makes the point that an episode of psychosis can be a genuine route to spirituality:

> Distress, even the distress associated with psychosis, can be hallowed ground upon which one can meet God and receive spiritual teaching. When we set aside neurobiological reductionism, then it is conceivable that during the passage that is madness, during that passage of tomb becoming womb, those of us who are diagnosed can have authentic encounters with God. These spiritual teachings can help to guide and encourage the healing process that is recovery.
>
> (Deegan, 2004)

Studies have shown that religious content occurs in 22% to 39% of psychotic symptoms in schizophrenia (Anderson-Schmidt et al., 2019; Siddle et al., 2002). A study of hospitalized bipolar patients found that

religious delusions were present in 25% and more than half of the hallucinations were brief, grandiose, and usually religious (Goodwin & Jamison, 1990). Ouwehand, Wong, Boeije, and Braam (2014) observed that some clients in their study "reported intense spiritual experiences during mania, accompanied by feelings of happiness or freedom. Mystical experiences of a sense of unity, of enlightenment, of the ascending of the soul or of the presence of the divine were reported" (p. 621). Edward Podvoll, a psychiatrist who developed a Buddhist mindfulness-based treatment model in use in Colorado, pointed out that genuine mystical experiences often occur in manic states: "There is a general agreement among those who have experienced it, that religious truths are realized, the religious truths, the ones of the desert fathers and the great mystics" (Podvoll, 1990, p. 118).

Since the earliest recorded history, experiences seen as psychotic from the modern perspective have been considered spiritual in different contexts. Hallucinations and visions of biblical prophets and saints, for example, have played an essential role in religion and the foundation of society itself for thousands of years.
p. 600 Socrates, who had a personal daemonic ↳ voice that guided him, declared, "Our greatest blessings come to us by way of madness, provided the madness is given us by divine gift" (Dodds, 1951, p.61). Based on a cross-cultural survey, anthropologist Raymond Prince (1992) concluded: "Highly similar mental and behavioural states may be designated psychiatric disorders in some cultural settings and religious experiences in others" (p. 289).

Within cultures that invest these unusual states with meaning and provide the individual experiencing them with group support, at least a proportion of these individuals may be contained and channeled into socially valuable roles. For example, McGruder's (2002) study of mostly Muslim Swahili people of Tanzania showed how tolerance, inclusion, and a religious interpretation resulted in higher rates of recovery for people meeting the diagnosis of schizophrenia than people with the same diagnoses in Western developed countries.

In a study of visions among Hispanic clinic patients, Lata (2005) found that "psychotic phenomena could occur in connection with spiritual experiences. Visions of loved ones who have died occur constantly, as well as visions of saints, angels, Jesus, and Mary" (p. 27). Other anthropological accounts show that babbling confused words, displaying curious eating habits, singing continuously, dancing wildly, and being "tormented by spirits" are common elements in shamanic initiatory crises. In shamanic cultures, such crises are interpreted as an indication of an individual's destiny to become a shaman, rather than a sign of mental illness (Halifax, 1979). In Asian cultures, problems associated with spiritual practices, such as disorientation and hallucinations, which in the West could be labeled "psychotic" are instead recognized as phenomena distinct from psychopathology.

Research on Spirituality and Recovery From Serious Mental Problems

Studies have shown that spirituality plays an important role in the recovery process. In fact, religious practices such as worship and prayer appear to protect against severity of psychiatric symptoms and hospitalization, enhance life satisfaction and speed recovery from psychosis and severe disorders (Koenig et al., 2012). Many patients make use of use of religious and spiritual practices during their recovery. In a survey of California service recipients, many reported they rely on the following religious/spirituality practices to support their mental health: prayer (73%), meditation (47%), spending time in nature (41%), and reading sacred texts or spiritual self-help books (36%) (Yamada et al., 2019). In a systematic review of studies among hospital clients on the relationship between client well-being and private prayer, Hollywell and Walker (2009) found that that prayer frequency was associated with less depression and anxiety. They concluded that prayer can be conceptualized as "a coping action that mediates between religious faith and wellbeing" (p. 634). Participation in church and other faith communities involves many of these supportive practices, including prayer, meditation, religious ritual, religious reading, and singing. In addition to the aforementioned benefits, studies have found that spirituality increases resilience to stigma (Chaudoir et al., 2012). Huguelet et al. (2011) found that ↳ the importance of spirituality was predictive of fewer negative
p. 601
symptoms, better social functioning, and improved quality of life among the 83% of patients who reported that religion had been helpful to them prior to their illness. Spirituality was unrelated to outcomes among the 14% with negative religious coping prior to their illness. Duran and Walters (2004) suggested that spirituality, including engagement in religious rituals and ceremonial practices, increases resilience to historical trauma among American Indians and Alaskan Natives, and perhaps others. In addition, spirituality may play a role in reducing substance abuse among people receiving mental health services, a well-documented problem that interferes with recovery (Huguelet et al., 2009).

Fallot (1998) analyzed the key religious and spiritual themes in recovery narratives drawn from spiritual discussion groups, trauma recovery groups, and other clinical groups at Community Connections, a mental health facility for people diagnosed with psychosis and severe disorders. He found that although organized religion had been experienced as stigmatizing and rejecting on some occasions, on the whole a personal, spiritual experience of a relationship with God was helpful in building hope, a sense of divine support and love, the courage to change, and to accept what cannot be changed. Participation in church and other faith communities provided clients with supportive practices including prayer, meditation, religious ritual, religious reading, and listening to religious music. In addition, spirituality played a positive role in coping with stressful situations as well as avoiding drug use and negative activities.

In another qualitative study, Jacobson (2001) conducted a thematic dimensional analysis of 30 recovery narratives. She identified "spiritual or philosophical" as an important theme in most of the narratives:

> In this model the "what happened" is a spiritual or philosophical crisis during which the self is destroyed and then recreated in the light of a newly realized truth. The crisis is an altered state of being … The greatest help comes when individuals are able to connect with some source of enlightenment; a community of practicing Buddhists, the Bible, treatises of philosophy or physics. Recovery is about enduring and coming out the other side … Coming back to life, in a recreated and enlightened self, the individual discovers new "wisdom and compassion." Those who have recovered, then, are obligated to demonstrate this wisdom and to practice compassion by reaching out to others who are in the midst of their own crises.
>
> (pp. 252–253)

Contemporary research on religious coping has generally supported the value of spirituality for persons with psychosis and severe mental disorders (Milner et al., 2019; Phillips et al., 2009). In a survey of more

than 2,500 individuals receiving mental health services, 80% reported that their religious beliefs and behaviors helped them cope with their symptoms, and agreed or strongly agreed that spirituality was important to their mental health (Yamada et al., 2019). In another study, 80% of a group of 406 individuals
p. 602 with psychosis and severe disorders in Los Angeles reported that their religious beliefs and behaviors ↳ helped them cope with their symptoms (Tepper et al., 2001). Thirty percent of this group agreed of the statement that religious beliefs and practices "were the most important thing that kept [them] going" (Tepper et al., 2001, p. 662). Some benefits from religion include feelings of optimism and comfort from giving up some sense of control over the difficulties surrounding psychosis and severe disorders, instead placing that control in the belief of a divine force. People with psychosis and severe disorders report that spirituality provides a sense of connection and support through contacts with like-minded individuals (Bussema & Bussema, 2000). Hope and security can also be derived from religious figures and texts that provide a model for persevering in the face of adversity, and from attributing difficult life circumstances to part of a divine plan in which the individual has a purpose (Fallot, 1998). Many people with psychosis and severe disorders experience fear, confusion, and helplessness that disrupt the internal order of their personality. According to Fallot (2001), "Religious faith develops in an unconscious, involuntary way. The faith creates an internal source of security; it offers the individual peace, inner strength and hope … faith in these circumstances can be regarded as the strongest defense mechanisms" (p. 115).

Phillips and Stein (2007) used a longitudinal design to examine religious attributions and their relationship with adjustment to psychosis and severe disorders. They administered subscales of the RCOPE (Pargament et al., 2000), a well-validated measure of religious coping, and measures of psychological adjustment to young adults living with bipolar disorder and schizophrenia in 2000 and again one year later. These participants, compared to nonpsychiatric samples from previous studies, were just as likely to use benevolent religious reappraisals (viewing one's challenges such as psychosis and severe disorders as part of a divine plan and an opportunity to grow spiritually). This form of religious coping has been associated with positive outcomes from stressful life events (Gall & Guirguis-Younger, 2013). In a study of adults experiencing their first psychotic episode, religious coping was related to better outcomes as well. Such strategies were found to be helpful for coping with mental health problems by offering hope and reestablishing a stronger sense of self (Miller & McCormack, 2006). Religious coping strategies may be especially helpful for some individuals with psychosis and severe disorders who receive services outside the public mental health system and may rely on alternative therapies (Sarris et al., 2011).

However, "punishing God reprisals" were linked to higher levels of distress and greater feelings of loss of a normal life as a result of psychosis and severe disorders (Phillips & Stein, 2007). Similarly, although Tepper et al. (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) some specific religious coping activities were associated with poorer outcomes.

Pargament et al. (1998) have described a form of "transformational religious coping" which involves
p. 603 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 (1998), Grof and Grof (1989), and Lukoff (2007, 2016), could fit these criteria. The psychotic break in these cases is a spiritual crisis and involves the restructuring of one's worldview. Pargament (2007) 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. With further refinement, mainstream psychological theory may be able to integrate transpersonal insights with regard to the spiritual dimensions of some psychotic episodes. Nixon et al. (2010 studied six people who self-identified as having benefited from psychosis in a spiritual and/or transformative manner. Themes that emerged from their interviews include: "embracing a spiritual pathway," and "re-alignment of career path." Overall, they conclude that "the results suggest that

at least for some individuals, the experience of psychosis can be an important catalyst for spiritual and personally transformative growth" (p. 1). Because outcomes can be so variable, the risk is assessments of poor prognosis risk becoming a "self-fulfilling prophecy." Emerging perspectives encourage broad spiritual competency among professionals and a general awareness of and openness to the possibility of developmental progress through crisis, similar to the positive outcomes after trauma termed "posttraumatic growth" (Bola & Mosher, 2003; Brook, 2019)

The Hearing Voices Movement distinguishes distress, isolation, and a sense of empowerment as distinct from the presence or absence in themselves of nonordinary experiences such as voice hearing (Romme et al., 1992). The movement, which brings together patients and professionals to advocate for change on the research, policy, and clinical practice levels, emphasizes the need to understand coping with the experience and finding a new relationship to it, not simply viewing it as psychopathology and then trying to remove it (Corstens et al., 2014). Other nonordinary experiences, such as unusual beliefs (including spiritual beliefs) and paranoia, also have wide prevalence: most do not find these experiences distressing or in need of any treatment (Bürgy, 2008; van Os, 2003; van Os & Reininghaus, 2016). This suggests the importance of greater openness to nonordinary experiences as expressions of human diversity, and for greater understanding how many people live with and benefit from these experiences.

At the same time, some patients have been found to hold distressing spiritual beliefs. One study of 52 psychiatric inpatients found that 23% believed that sin-related factors, such as sinful thoughts or acts, were related to the development of their illness (Sheehan & Kroll, 1990). This is clearly a guilt-inducing belief for which there is no evidence, and one that the vast majority of religious professionals would challenge. When I (DL) was a psychologist at Camarillo State Hospital, I collaborated with a rabbi in leading groups for patients, and this was one of the beliefs we regularly encountered. He made a point of disputing such assertions when they were voiced, using both Old and New Testament citations.

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Treatment of Serious Mental Problems: Case Example

To illustrate the role spirituality can play in therapy, I (DL) will describe how spirituality was important in my own recovery from an episode of psychosis (see Lukoff, 2014, for a fuller account). Joseph Campbell once said if there was a sign in a hallway that said: "Lecture on God turn right. Meet God turn left," most people would go to the lecture. I was one of those who not only turned left to meet God but became God—or at least Buddha and Christ. This happened in 1971 when, at the age of 23, following my first LSD trip, I spent two months firmly convinced that I was a reincarnation of both Buddha and Christ. I spent many sleepless nights holding conversations with the "spirits" of eminent thinkers in the social sciences and humanities, including talks with R. D. Laing, Margaret Mead, Freud, and Jung. I also conversed with Bob Dylan and Cat Stevens to learn about how to get the new "Holy Book" I was writing out into the world which would unite all the peoples of the world for the first time. I made 40 photocopies of the book and mailed them to my family and friends, and passed them out in the streets of Berkeley, California.

For those two months, my episode met the diagnostic criteria for acute schizophrenic reaction in the second edition of *Diagnostic and Statistical Manual* (DSM) (which was in use at the time). In the current DSM-5 (American Psychiatric Association, 2013), that experience could be diagnosed as a hallucinogen induced psychotic disorder. As has happened to others (Lukoff & Everest, 1985), I could have been diagnosed with a psychotic disorder if I hadn't been supported by friends who took me in for a total of eight weeks. They provided sanctuary for me and helped me to get grounded again in the everyday social world and consensual reality. Without their help, I might have been confined in a psychiatric hospital, diagnosed with a lifelong psychotic disorder, and "treated" with medication.

The support of my friends during this time emulated the Diabasis program that was developed in 1974 in San Francisco by Jungian analyst John Perry for people undergoing a first psychotic break such as mine. Diabasis created a homelike atmosphere where diagnostic labels were not used. Staff members were selected for their ability to be comfortable with the intensive inner processes of persons in psychotic states. Patients were encouraged and supported to follow their inner journeys while being taken care of and protected from harm. The average length of stay was 48 days. Perry (1998) reported that many severely psychotic clients recompensated within two to six days *without* medication. Unfortunately, outcome data were not collected for this sample. Diabasis closed down after a few years due to budget cutbacks and political opposition in the mental health system.

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 to 1983, roomed six clients at a time up to several months, with three to four staff on premises. The nonprofessional staff were trained to view psychotic experiences as a developmental stage that can lead to growth, and which often contains a spiritual
p. 605 component such as mystical experiences. The staff were trained to "be with" in a nonintrusive ↳ and nonjudgmental way, similar to "being with" individuals going through a difficult psychedelic drug experience. 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 medication stunted the possible growth-enhancing process of the psychotic episode (Mosher & Menn, 1979).

Outcomes from Soteria were compared to a standard program, a community mental health center inpatient service consisting of daily pharmacotherapy, psychotherapy, occupational therapy, and group therapy (Mosher et al., 1975). Clients' length of stay was longer at Soteria than in the comparison program (mean of 166 days vs. 28 days) (Mosher & Menn, 1979). But most patients recovered in six to eight weeks without medication (Mosher et al., 2004). A recent meta-analysis of data from two carefully controlled studies of Soteria programs found better two-year outcomes for Soteria patients in the domains of psychopathology, work, and social functioning compared with similar clients treated in a psychiatric hospital (Bola & Mosher, 2003).

In Western Finland, psychiatric crisis services are provided by the Open Dialogue approach, which has gained growing attention worldwide by achieving significantly higher rates of recovery than traditional care for schizophrenia and psychotic disorders. At five years, among the sample of 75 patients, 79% were asymptomatic and 80% were working, in school or seeking employment. Only 20% were continuing to take antipsychotic medication, and antipsychotic medications were not used with 70% during treatment, in stark contrast to areas where Open Dialogue is not used (Seikkula et al., 2006). Persons experiencing a psychotic crisis are treated within 24 hours, primarily in their homes, by a family therapy-trained team that maintains consistent contact through ongoing treatment meetings with the family and close social network. The person going through the crisis is included in conversations about the crisis and how to respond; delusions or perceptions with religious content are listened to equally in the conversation, from a standpoint of tolerance of uncertainty and trust that meaning will eventually emerge. Treatment with antipsychotic medication is routinely delayed or found to be unnecessary, and socialization into a new identity as a mental patient is avoided (Seikkula et al., 2003). Psychosis is understood not as arising from individual disease or deficit but within the relationships and communication between people (Bergström et al. 2018). While reliance on a clinical team, flexibility and mobility, and frequent extended therapeutic meetings at the earliest onset of a crisis are initially labor-intensive, Open Dialogue's high recovery outcomes have led to reduced costs for mental health services overall (Seikkula et al., 2003).

The findings from Soteria and Open Dialogue also suggest reduced reliance on antipsychotic medication as a component of recovery. In addition to reducing stigma and the risk of facilitating career patients, less medication might enable some people to increase access to the positive potential within their spiritual experiences. Growing interest in medication reduction and withdrawal reflects both the escalating use of

medications in society and increased recognition of adverse effects and limited efficacy for many (Hall,
p. 606 2018; ↳ Larsen-Barr et al. 2018; Whitaker, 2010). Some patient advocates including The Icarus Project have encouraged a "harm reduction" approach where using medications is more tailored to individual choice around risks and benefits, rather than a one-size-fits-all treatment for everyone with a certain diagnosis. In addition, The Icarus Project also supports individuals who want to explore withdrawing from their medications flexibly, avoiding more absolutist approaches (Aldridge, 2012; Hall, 2010). Consumer-driven organizations focus on finding alternative approaches to manage symptoms and avoid crisis. This often means redefining experiences in a spiritual framework, with an emphasis on self-compassion when challenged by the difficult parts of one's life journey, rather than seeing things through a disease and illness lens (Larsen-Barr et al., 2018).

Therapeutic Approaches

Psychotherapy can help patients shape their psychosis and severe disorders into a coherent narrative, to see the "message" contained in their experiences, and to create a life-affirming personal myth (belief system) that integrates their experience. As I (DL) have documented in published case studies (Lukoff, 1988, 1993, 2015a; Lukoff & Everest, 1985), and observed in my clinical practice, psychotherapy can help some individuals probe the personal meaning of their symptoms and also see the universal dimensions of their experiences. Based on what I learned in my own integration process, and through my work with other individuals who had similar episodes, psychotherapy focused on integrating such experiences involves three phases:

Phase 1: Telling One's Story

Phase 2: Tracing Its Symbolic/Spiritual Heritage

Phase 3: Creating a New Personal Mythology

Phase 1: Telling One's Story

People with psychosis and severe disorders are usually not asked to recount or reflect on their experiences. Yet telling one's story is an important first step in recovery. Some clinicians have expressed the concern that having patients discuss their delusional experiences could exacerbate their symptoms by reinforcing them. I developed and led a 12-week holistic health program conducted at a state psychiatric hospital in which participants were encouraged to actively explore their psychotic symptoms. They participated in groups such as "Schizophrenia and Growth," which encouraged them to compare their experiences to mystical experiences, Native American vision quests, and shamanic initiatory crises. Patients were assessed biweekly for psychopathology, and the data showed that telling their stories did not result in exacerbation of symptoms (Lukoff et al., 1986).

Phase 2: Tracing Its Symbolic/Spiritual Heritage

Jungian analyst John Beebe (1982) has noted:

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> Minimally, the experience of psychotic illness is a call to the Symbolic Quest. Psychotic illness introduces the individual to themes, conflicts, and resolutions that may be pursued through the entire religious, spiritual, philosophical and artistic history of humanity. This is perhaps enough for an event to achieve.
>
> (p. 252)

My personal call to the symbolic quest began after discovering the works of Joseph Campbell a few months after my episode. He saw the Hero's Journey as similar to the inward journey of schizophrenia (Campbell, 1972). He posits that whereas myths are metaphors for journeys into the psyche, psychosis is an actual journey into the psyche.

But like others with whom I have worked who developed grandiose delusions such as that they were god or the messiah, these stereotypical delusions of power were embarrassing to me later. I entered a five-year Jungian analysis a few years after the episode, which enabled me to make many positive links between my experiences and the worlds of myth and religion. Many religious professionals now recognize the potential spiritual value of mental health episodes. Father Jerome Stack (1997), a Catholic chaplain for 25 years at Metropolitan State Hospital in Norwalk, California, has observed that people with psychosis and severe disorders often do have genuine religious experiences:

> Many patients over the years have spoken to me of their religious experience and I have found their stories to be quite genuine, quite believable. Their experience of the divine, the spiritual, is healthy and life giving ... It is important not to presume that certain kinds of religious experience or behavior are simply "part of the illness"
>
> (p. 23).

James Hillman (1983) pointed out that "recovery means recovering the divine from within the disorder, seeing that its contents are authentically religious" (p. 10). The search for genuine spiritual aspects of psychosis and severe disorders by exploring parallels in traditional myths and religious texts has played a role in the recovery of others (Lukoff, 1988, 1993, 2015; Lukoff & Everest, 1985). In my own case, soon after my episode, I realized that I really had very little knowledge of Christ or Buddha at the time I assumed their identity. This led me to explore Christianity, Buddhism, and other forms of spirituality for the first time in my life. Perry (1998) noted that after a psychotic episode, "What remains ... is an ideal model and a sense of direction which one can use to complete the transformation through his own purposeful methods" (pp. 34–35). I now view my own experience of having "been" Buddha and Christ as revealing ideal models for my life and as my spiritual awakening.

Phase 3: Creating a New Personal Mythology

Personal mythology is an individual's belief system of complementary and contradictory themes that shape
p. 608 a person's view of the world, shape expectations, and guide decisions ↳ (Feinstein & Krippner, 2008). Personal myths address life's most important concerns and questions, including the following:

1. Identity (Who am I? Why am I here?)
2. Direction (Where am I going? How do I get there?)
3. Purpose (What am I doing here? Why am I going there? What does it all mean?)

Weaving the experience of psychosis and severe disorders into a life-affirming personal mythology is essential for recovery. Experiences of nonordinary reality, such as dreams and psychedelic drug experiences, as well as delusional and hallucinatory experiences from psychosis and severe disorders can play a significant role in shaping positive personal mythologies. All of these involve transcendence of ordinary life concerns and an experience with a "higher" or "deeper" reality. Such experiences can become the foundation for a new personal mythology that is growth-enhancing and spiritually supportive.

My personal journey of finding Purpose has involved publishing case examples highlighting the role spirituality has played in the recovery of others as well as my own recovery. I also published research and

literature reviews on this topic, and presented at American Psychological Association, American Psychiatric Association and rehabilitation conferences in order to increase the awareness of mental health professionals about the important role of spirituality in recovery and in mental health in general. This work also led me to propose a new category for the DSM-IV (also in the current DSM-5) entitled Religious or Spiritual Problem (V62.89).

During the past 30 years in my clinical practice as a psychologist at UCLA-NPI, Camarillo State Hospital, the San Francisco VA Medical Center, and private practice, I have often found myself face to face with individuals who are having or have had delusions and hallucinations similar to mine. I believe that my ability to work effectively with those individuals has been aided by being given a rare opportunity to journey through the complete cycle and phenomenology of a naturally resolving psychotic episode. For my dissertation, I developed and led a holistic health program for patients at Camarillo State Hospital that included meditation, yoga, and exploration of the similarities between the patients' experiences and those of shamans, Native American vision quests, and artists such as van Gogh. Thus my psychotic episode held within it the archetypal gift of becoming a Wounded Healer, which has provided me with the ability to work more effectively with persons in the midst of or recovering from psychotic episodes.

My (WH) recovery journey has some overlap with Dr. Lukoff's. I was told I would be managing a chronic thought disease, schizoaffective disorder schizophrenia, for the rest of my life, and I spent 15 years on a disability check struggling to regain my life. Today I no longer take medications and have become a therapist working actively to create alternative approaches to psychosis and severe mental disorders, including my work with the Hearing Voices Movement and Open Dialogue. Key for my recovery was
p. 609 connecting ↳ with a supportive patients' community, including Freedom Center and The Icarus Project, where we view ourselves beyond the medical psychiatric model. I learned about the rich history of alternatives to the medical model, and interviewed scientists, journalists, doctors, activists, and artists on the Madness Radio show I host and in the book *Outside Mental Health: Voices and Visions of Madness* (Hall, 2015). Through years of work with community support groups I wrote *Harm Reduction Guide to Coming off Psychiatric Drugs* (2010), which has been translated into 14 languages and is widely used in the mental health recovery movement. Currently, I am a Ph.D. candidate at Maastricht University School for Mental Health and Neuroscience as I strive to stay on the forefront of leading innovations in psychosis treatment in the United States and around the world. The death sentence of chronic mental illness was for me not a breakdown but a breakthrough to a different version of who I am.

As I challenged mainstream understandings of the altered states I experience, I drew strength from my mixed Choctaw American Indian heritage. Different realities became for me not signs of illness but spiritual messengers inviting my curiosity and discovery. Today I am less isolated, more in control, and less terrified than I was that day when a team of doctors gathered around a consulting table to pronounce me schizophrenic. But my most "florid" symptoms of that time, my unusual beliefs, my conversations with voices, my paranoia, my contemplation of suicide, my silent inward withdrawal, my perception of prophetic omens … all of that remains. I meet these experiences not with fear I am relapsing or as signs of disease, but as challenges to discover guidance from the dimension of spirit and ancestors. I am doing something completely different from what medical and mass media narratives say I should be doing: I am regaining my well-being in the world while at the same time losing touch more and more with "reality." My madness is leading me somewhere that is more real than what everyone seems to say is real. I'm leaving behind not just the doctors' diagnosis, but also the mechanistic, soulless, and "objective" reality that gave rise to it (Hall, 2015).

Consumer Movements Focused on Spirituality

In November 2004, the passage of Proposition 63—the Mental Health Services Act—by voters in California provided the California Department of Mental Health with increased funding to support county mental health programs. Long-time consumer advocate Jay Mahler saw this as an opportunity to develop a systematic approach to remediating the neglect of spirituality in the public mental health system. In August 2006, Mahler invited a diverse group of 20 consumers, family members, and service providers, including DL, to form a "spirituality workgroup." This group convened monthly in its first year to share knowledge about diverse spiritual practices, religious traditions, and ethnic and cultural experiences in recovery. This dialogue led to the development of a concept paper for a state-wide project to find effective, collaborative means to lead the public mental health system in California to inquire about, embrace, and support the spiritual lives of the people it ↳ serves. The recently formed California Mental Health & Spirituality Initiative was funded by 53 of the state's 58 counties. Specific activities of the initiative have included conferences on mental health and spirituality, a website (http://www.mhspirit.org), community dialogues, teleconferences, development of online and face-to-face curricula, as well as surveys of mental health service recipients (individuals and families), provider agencies, and county mental health directors.The surveys showed that both patients and California County Behavioral Health Directors are supportive of integrating spirituality into mental health services. In the survey conducted face-to-face of by phone, more than 90% of the county health directors said "strongly agree" or "agree" in response to the following three statements.

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Q1. "Spirituality is an important recovery resource in mental health treatment." (92%)

Q2. "Spirituality is an important wellness resource in mental health prevention." (94%)

Q3. "Spirituality is an important element of multicultural competency for mental health providers." (98%)

This was even higher than the percentage of consumers who agreed that "Spirituality is important to my mental health"—82%. These findings provide support for county and other public mental health programs to include spirituality as a component of recovery (Yamada et al., 2019).

Conclusion

The mental health professions have a long history of ignoring and pathologizing religion. For instance, Freud reduced the "oceanic experience" of mystics to "infantile helplessness" and a "regression to primary narcissism" and described religion as an obsessional neurosis (Freud, 1989/1927). Albert Ellis asserted, "The less religious [patients] are, the more emotionally healthy they will tend to be" (Ellis, 1980, p. 637). But the data reviewed earlier show otherwise: Religion is overwhelmingly associated with positive mental health. For many people, both with and without psychosis and severe disorders, having a relationship with a higher power is the foundation of their psychological well-being. Providing spiritual support involves supporting a person's sense of connection to a higher power (i.e., God or other transcendent force) that is actively supporting, protecting, guiding, teaching, helping, and healing. Some researchers have suggested that the subjective experience of spiritual support may form the core of the spirituality–health connection (Mackenzie et al., 2000).

In most cases, mental health service providers can provide spiritual support to people coping with psychosis and severe disorders by devoting some time to exploring spiritual issues and asking questions to discover a client's perspective on the deeper meanings in their life. They can initiate support of a patient's spirituality through a spiritual assessment ↳ such as the SSOPP interview created to elicit religious and spiritual beliefs

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and practices, which is currently being used in public county behavioral health agencies in California. After some screening questions (the first "S" in SSOPP) to determine if conducting a spiritual assessment is appropriate for a given patient, this interview addresses the following:

- **S**trengths: Religious/spiritual strengths and coping resources
- **O**rganized religion participation
- **P**ersonal religion/spirituality
- **P**roblems: Religious/spiritual problems

The SSOPP is designed to be administered in three to five minutes as part of an intake or the questions can be asked as religious or spiritual issues arise in treatment (Lukoff, 2015b).

Other ways mental health service providers can provide spiritual support that are both evidence based and appropriate include the following:

Educating the client about recovery as a spiritual journey with a potentially positive outcome.

Encouraging the client's involvement with a spiritual path or religious community that is consistent with their experiences and values.

Educating clients about individuals who have recovered through accepting and living with nonordinary and altered states experiences otherwise seen as psychosis, such as hearing voices, seeing messages, and having strange beliefs. Such education can include joining hearing voices groups and patient support groups where experiences and tools for coping are shared.

Encouraging the client to seek support and guidance from credible and appropriate religious or spiritual leaders.

Encouraging the client to engage in religious and spiritual practices consistent with their beliefs (e.g., prayer, meditation, reading spiritual books, acts of worship, ritual, forgiveness, and service). At times, this might include engaging in a practice together with the patient such as meditation, silence, or prayer.

Modeling one's own spirituality (when appropriate), including a sense of purpose and meaning, along with hope and faith in something transcendent.

People recovering from psychosis and severe mental disorders have rich opportunities for spiritual growth, along with challenges to its expression and development. They will find much needed support when they are clinically guided to explore their spiritual lives.

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