

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

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

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

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

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

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

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

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

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

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

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

Dissonance

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

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

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

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

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

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

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

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

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

Opening Up

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

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

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

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

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

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

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

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

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

Contact with Caution

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

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

he introduced the possible existence of a dimension of the self that is beyond the conscious ego and through which the spiritual manifests itself. James concluded (and after him Jung, 1961) that our consciousness is a small and limited part of a wider consciousness. Around our conventional awareness and separated by a thin boundary lie other types of consciousness, giving access to other realities and knowledge. James sought to legitimize the study of the entire range of human experience including religious experience, mystical states, psychic phenomena, and non-Western conceptions of personality and consciousness. In line with this pioneering work, current conceptualizations of transpersonal experiences view them as going beyond the ordinary sense of identity or personality to encompass wider dimensions of the psyche and the cosmos (Wilber, 1977).

At this level, the changed ontology is reflected mostly in clinicians' ways of knowing—that is, their epistemology. Clinicians may use various means of accessing transcendental knowledge about themselves, their clients, clinician-client relationships, and the best ways to help their clients. One spiritual way of knowing the world may include therapists' ability to use altered states of consciousness to gain access to intuitive or transcendental knowledge (Sollod, 1993). The clinician may also openly accept and utilize knowledge accessed by the client through such "channels."

There are various techniques known to provide access to such knowledge about the self, such as the different types of meditation (Glickman, 2002; Germer, Siegal, & Fulton, 2005), as well as channeling and regression therapies (Jue, 1996). For example, mindfulness meditation entails clearing the mind and observing mental, emotional, or imaginary occurrences while accessing altered states of consciousness. The meditator may receive insights: some truth derived from a universal intelligence (or wisdom). The process is similar to the reflective orientation advocated by most schools of psychotherapy. In the words of Epstein (1995), "This examination is, by definition, psychological. Its object is to question the true nature of the self and to end the production of self-created mental suffering." (p.3). Insights derived from access to altered states of consciousness may be expected to include new perspectives and more holistic and integrative insights regarding life issues and struggles. For example, in the case of a young woman who complained of a conflictual relationship with her husband, the focus was the couple's inability to share parenthood; the client felt her husband was withdrawing

and abandoning her to handle their three kids by herself. After a couple of sessions the feeling in the room was that therapy was not progressing. Between sessions, the therapist engaged in meditation focusing on the case and received information pointing toward the father's fears about the oldest son (10 years old) being gay and his confusion about how to approach the matter. After some hesitation and tentative exploration around the issue, the therapist decided to share the results of her meditation with the client. The relevance of this issue was quickly confirmed and facilitated a dramatic shift in the course of therapy.

In this phase, clinicians accept that an alter-reality exists and that spiritual issues need to be addressed. They actively collect pertinent information via various channels but remain hesitant to use such data in therapeutic interventions with clients. They may well use spiritual dimensions when thinking about the client's presenting problems, yet they do not present themselves openly as spiritual or holistic therapists. Various reasons may underlie such hesitation even among clinicians who have gone beyond any residual conscious and unconscious doubts about spirituality characteristic of level two. They may lack knowledge and experience in implementing such interventions, and they may fear disapproval by potential clients and their professional community. In general, the clinician at this level may be described as a spiritual novice.

In sum, in this phase of incorporating spirituality into therapy, clinicians acknowledge the existence of a spiritual realm and recognize and utilize the capacity to know more about the self and the universe through connection to higher levels of consciousness. They tend, however, to avoid actively and openly employing spiritual techniques in therapy sessions, and they use them only sporadically and with caution. For example, they may meditate to understand the client's situation and get help from what they perceive as higher wisdom or external guidance and use this information in their intervention without revealing the source of their insights to their clients.

Some questions surfacing naturally at this level include: Who should collect the transcendental knowledge, and how should it be used? Is it the professional and ethical duty of the clinician to actively use their spiritual abilities for the benefit of their clients? Should the clinician meditate on behalf of their clients, even if this was not part of the therapeutic contract? If so, what measures can the clinician use to assure this

knowledge is reliable? Should the client be asked to open up for such experiences (e.g., to meditate) and then discuss the experiences with the therapist? How active should clinicians be in bringing in their own spiritual worldview and knowledge? Should the clinician actively present the client with these ways of knowing?

Engaged

In this fourth level, spirituality is fully and actively incorporated in mental health interventions. Clients are helped to actively engage in exploring their relationship with the cosmos/higher power and therapists freely use their own power or connection with higher existence to facilitate healing. Such clinicians own a distinctly spiritual and holistic worldview, and actively apply it in defining clinician-client relationships, conceptualizing presenting problems, and introducing various techniques and interventions in and outside therapy sessions. The various spiritual definitions of the relationship and the therapeutic process, as well as the therapeutic techniques, are derived from healing traditions, which emphasize the central importance of the connection of all life to cosmic realities. In this view, healing is usually seen as restoring a condition of wholeness or harmony, in contrast to psychotherapeutic approaches that perceive human beings as isolated from universal and spiritual purposes (Sollod, 1993).

The ways in which people are interconnected with one another (including with the therapist) can also be explored as part of the spiritual connection with the universal collective consciousness. This involves seeking meaning behind significant relationships and life events in a different manner than the usual line of inquiry, simply because it relies on different assumptions regarding reality. From such a perspective, a search for an assumed pre-existing and higher common purpose, which emphasizes primarily spiritual connectedness and a natural unity between clinician and client, is common. (Birnbaum, 2005).

For example, rather than the “why me?” question clients often ask regarding their problem (and therapists in reference to certain clients), clients may become aware of a sense of mission in their current life in which the current problem plays some role. The following questions can be asked: *Assuming there is a higher purpose behind your life events and that they aren't random*, what do you think is the meaning of your illness/problem at this point in your life? What could be the meaning of the fact that the *two of us* are working together in this particular setting?

Therapists can ask themselves, “How do I understand the assignment of this particular client *to me, now?*”

Clinicians and clients can work this way during ordinary waking consciousness (everyday “mindfulness”) and also using altered states of consciousness. Interconnectedness can be taken a step further when the therapist has expertise in entering different states of awareness and can use this ability to enhance a variety of therapeutic processes. In such states, clinicians rely on factors outside their ordinary ego to facilitate healing. They are then open to other states of receptivity, which may involve a deep feeling of unselfish love, enhanced sensitivity to the other, and contact with inner resources of compassion and understanding (Sollod, 1993), as well as transcendental knowledge. Clients too may be encouraged to use various techniques such as meditation, channeling, past life regression (Jue, 1996), or other healing procedures to find out about themselves, about their problems and about the universe.

This phase of incorporating spirituality in therapy raises specific ethical and professional issues. If clients can be encouraged to acquire such skills, which clients are appropriate for it? Can every client benefit from some form of spiritual self-inquiry? What would indications and contraindications for this be, in terms of the client and their life circumstances? With what cultural and special populations and problems, at what ages and developmental stages, and at what point in therapy might such interventions be more or less appropriate?

Finally, this phase may represent the apex of clinicians' professional-spiritual development and the development of their self-identity. At this stage, therapists may have a sort of identity crisis (or opportunity), as they wonder: Am I a therapist or a healer? Is my therapeutic work geared toward problem solving or toward a spiritual quest? Are these two distinct ways to achieve transformation of the self? How do I as a clinician define myself, the type of work I do and the kind of service I provide for my clients?

Discussion

Four levels of therapist incorporation of spirituality in mental health practice have been suggested and illustrated. The first two levels represent primarily epistemological and ontological shifts in clinicians' worldviews, while the next two levels reflect translation of the continuing shift into action. The four levels taken together are viewed as developmental. They involve a

gradual increase in the centrality of spirituality in mental health intervention, each presenting different associated professional dilemmas, ways of conceptualizing the relationship, and roles clinicians play in therapy. Important implications relating to this developmental process revolve around two major themes: similarities and differences between psychotherapy and healing and the changes implied by this model in the realm of the therapeutic relationship.

Sollod (1993) has suggested that the similarities between psychotherapy and healing have to do with the therapeutic situation, involving a client with a problem and a helper who is viewed as the potential healer. However, following Welwood (1985), we might want to distinguish between the processes of psychotherapy and of spiritual quest. Are these simply two different approaches to achieve mental health and personal fulfillment?

In a lecture on mindfulness and healing, Epstein (2005) provided an interesting working assumption that identifies the need to employ spiritual techniques: "You can't solve a problem with the same consciousness that created it." His approach emphasizes that healing is about our relationship with and attitude toward our experiences, among them our illness. He argued that people who seek cure are those who look for a way to get rid of the sickness and make it disappear, whereas people who seek to heal themselves engage in a journey of exploring and studying their true self. Such a mindful journey encourages the client to ask: Is there a meaning and a message behind what is happening in my mind? What is the opportunity? How can the problem serve as a vehicle to healing? In other words, Epstein talks about healing the whole for the sake of curing the ill part. In this approach, the clinician is not viewed just as a therapist or a practitioner but as a healer. Thus, the different developmental levels discussed in this paper may also be conceived as involving changes in the role of the clinician from curing to healing.

The shifts in understanding, learning, and treating necessarily lead also to a change in clinicians' professional identity and self-perception. Therapists who perceive themselves and their role differently may be expected to structure different types of relationships with their clients while trying to sort out some of the dilemmas connected to spiritual practices. For example, Sollod (1993) suggested that in cases where altered states of consciousness are used in the course of therapy, there is no clear separation between the processes of the healer and those of the client, and these lead occasionally to

the point of "mindful fusion." This unusual fusion contradicts the focus in traditional dynamic approaches on differentiation between therapist and client. Even if we were to set aside such untraditional phenomena, mutual implementation of spiritual practices in therapy can be seen as an aspect of human interconnectedness with the potential to transform the clinician-client relationship into a mutual spiritual journey.

Birnbaum and Birnbaum (2005) suggested that spiritual practices, which demand special qualifications, should be carried out only by trained professionals and that careful appraisal should be employed as some of these practices and ways of viewing the world may not be suitable for everyone. Spiritually-oriented and trained clinicians should be able to assess, using the various spiritual means at their disposal, whether their clients are ready and open to view the world from a transpersonal perspective and to use transpersonal ways of knowing in the therapeutic session. Clinicians will obviously collect and use information from the various sources they believe in (both traditional and spiritual), but the introduction of different ways of thinking and working on the problem or illness should be guided first and foremost by the needs and mental and spiritual condition of the client.

The view presented here is an attempt to integrate the different voices that are raised in reference to spirituality and therapy and to make sense of the various modes in which spiritually-sensitive therapists work. We do not, however, suggest that all clinicians should examine themselves according to our proposed model and find ways to acquire transpersonal strategies. It may well be that the incorporation of spirituality in clinical work best begins naturally with the clinicians' awareness of clients' spiritual needs, and that empathic and sensitive clinicians would not ignore such needs regardless of their personal religious or spiritual preference or lack thereof.

The diverse changes discussed here might serve to encourage us all to expand our views regarding the situation in which one human being seeks help from another. Clinicians need not experience themselves as healers if they feel detached from certain connotations associated with that concept; however, they should take into account that there is more to mental health than the therapy of the psyche.

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