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ORIGINAL PAPER

The Body, the Mind, and the Spirit: Including the Spiritual Domain in Mental Health Care

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Abstract

This article supports the expansion of Engel's (Science (AAAS) 196(4286):129–136, 1977) biopsychosocial model into a biopsychosocial-spiritual model, as Sulmasy (The Gerontologist 42(5):24–33, 2002) and others have suggested. It utilizes case studies to describe five areas of clinical work within mental health (religious grandiosity, depression and grief, demoralization and suicidality, moral injury, and opioid use disorder) with emerging evidence for the inclusion of the spiritual domain in addition to the biological, psychological, and social. For each clinical area, an underutilization of the spiritual domain is compared with a more developed and integrated use. An argument is made for continuing to develop, understand, and utilize a biopsychosocial-spiritual model in mental health.

Keywords Biopsychosocial-spiritual model · Spiritually-integrated care · Spiritual care · Spiritual domain · Chaplaincy · Religious grandiosity · Depression · Grief · COVID-19 · Demoralization · Suicidality · Moral injury · Substance use disorder · Opioid use disorder

Introduction

Engel (1977) introduced the biopsychosocial (BPS) model within psychiatry. This framework, a corrective to biological reductionism, has shown its relevancy within mental health care and beyond, especially in the treatment of chronic illnesses that cannot be understood without factoring in social-cultural environments and human experience. Although critiques remain related to its overall conception (Benning, 2015; Ghaemi, 2018) or as to whether healthcare systems have been structurally

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enabled to allow for a BPS approach (Wade & Halligan, 2017), Engel's framework has been widely embraced as both a philosophy of overall medical care and research, and as a guide for clinical encounters (Fava & Sonino, 2017).

Sulmasy (2002) argued for the expansion of the biopsychosocial model to include the spiritual, noting that without the spiritual domain we do not understand our patients as whole persons. His argument has been especially resonant in palliative and hospice care given that spiritual needs may appear more dramatically when medical cure is no longer possible. "At the end of life," he writes, "the only healing possible may be spiritual" (2002). As with the biopsychosocial, this argument is also relevant to chronic conditions with which patients in recovery must learn to live, rather than expect a medical cure. Facing these kinds of illnesses, Sulmasy might reason a spiritual experience; such an experience "grasps persons by the soul as well as by the body and disturbs both" (Sulmasy, 2006, p. 17).

Recent years have seen increasing interest in spirituality in medical research, and important efforts to address the spiritual needs of patients in various healthcare settings (see Carey & Mathisen, 2018). Relatedly, the field has seen multiple and varying conceptualizations of spirituality, with little consensus emerging (Saad et al, 2017). Despite these gains, and perhaps due in part to the challenges around conceptualization, the spiritual domain currently remains the least addressed dimension of a BPS approach.

In effect, twenty years after Sulmasy's proposal, the full deployment of a biopsychosocial-spiritual (BPS-S) model remains elusive or incomplete in many health care settings, including mental health. As an illustration, searches on Scopus and Google Scholar indicate that BPS models are referenced without the spiritual domain 89% (Google) and 97% (Scopus) of the time.[1] Even when the spiritual is included, common pitfalls remain, such as relegating the spiritual to the other domains (i.e., considering it a subset of the social, psychological, or even medical; see, for example, Cairns, 2012), or reducing spiritual assessment to the documentation of religious affiliation (Ferrell, 2017).

This paper examines the clinical consequences of incomplete or underdeveloped attention to the spiritual domain in mental health. It offers five depersonalized and composite case studies, each of which synthesizes the lived experience of its authors (all chaplains working in mental health), with emerging evidence related to the incorporation of specialized spiritual care in mental health treatment. Each of the case studies, then shows what utilizing the spiritual domain offers, and, correspondingly, what is missed when it is not engaged.

[1] Google scholar search revealed 320,000 results using search for keywords: "biopsychosocial" OR "bio-psycho-social." Searching the same keywords with the exclusion of "spiritual" revealed 281,000 results, while searching the results that did include "spiritual" yielded 39,200. A similar search on Scopus using the AND vrs. AND NOT operators revealed 11,637 results for "biopsychosocial OR "bio-psycho-social" with 11,264 not involving the word spiritual anywhere in the title, abstract, or keywords, and with 373 involving the word spiritual along with BPS. All sets of search results showed an increase in results over time, but with BPS at a faster rate of increase than BPS + spiritual.

Background and Methods

The primary authors of this paper are chaplains serving in different mental health settings at a Department of Veterans Affairs (VA) medical center in Connecticut. On the whole, VA has worked to prioritize spiritual wellbeing and to integrate spiritual care. The VA Whole Health program, for example, explicitly includes spiritual health as a component of the "circle of health" (see va.gov/wholehealth). VA has also sought to improve chaplains' knowledge and skills related to mental health care, as well as to better integrate chaplain and mental health services (Nieuwsma et al., 2015, 2017).

This project began with the identification of clinical areas in which we, the authors, have experienced the spiritual domain being underutilized or omitted in entirety. We drafted a case study related to each clinical area using deidentified and/or composite examples from actual clinical encounters by one or more of us. Reasons for the underutilization of the spiritual domain were hypothesized and are included here. We worked as a group to refine the case study and to review which theories or conceptual understandings might inform our approaches. Then, individually, we each generated questions related to how we might approach the situation, or what we might be curious about if we were called to provide spiritual care in the given situation. These questions were compiled, with duplicates combined or removed, and are reproduced here in their entirety.

Results

Our results are listed below and summarized in Table 1. Each follows the methodology described above: 1. A description of the case study; 2. Reasons as to how/why the spiritual domain might be underutilized; 3. An overview of research and/or conceptual understandings related to the integration of the spiritual domain in the related clinical area; 4. The list of questions generated by the chaplain authors; 5. A summary of what would be lost in each case without engaging the spiritual domain. This paper does not review best practices or implementation models for the integration of the spiritual domain, it simply seeks to offer a study of what is added when the spiritual domain is engaged.

Clinical Area I: Religious Grandiosity

Andrew is a 35-year-old man diagnosed with schizophrenia. He was recently evicted from an apartment and has been staying at the local homeless shelter. He was raised in a local African Methodist Episcopal (AME) church, at which both of his parents are pastors. He often presents to the emergency room reporting that he is a prophet, a messenger sent to speak God's truth to a fallen world.

Table 1 Summary list of presented case studies

Presenting clinical issues	Reasons for spiritual domain underutilization	Themes of questions generated by chaplains	Clinical gains through integration of spiritual domain
Religious grandiosity	Religious/spiritual content explained as psychiatric symptomology Fear of endorsing delusions Concerns that spiritual domain is outside scope of practice	Impact of family/cultural background and values Meaning and purpose Significance, worth, and appropriate healthy self-esteem Sense of control Grief and Loss	Increased treatment adherence through recognition and integration of this aspect of identity Utilization of spiritual resources for positive coping Strengthened therapeutic alliance
Depression and grief	Lack of explicit identification with religious or spiritual tradition Grief care considered to be exclusively in psychological domain	Framing grief as a human experience Recalling and retelling story of relationship Validating experience of loss Facilitating closure, mourning, and ritual Exploring spiritual and/or transcendent connection to loved one	Allow space for the gifts of grief Opportunity for shared ritual
Demoralization and suicidality	Fear of disturbing protective factor	Witnessing and acknowledging weariness, "stuckness" Exploration and expansion of protective factors Locating resources for hope practices	Utilization of strength-based protective measures Exploration of hope as both a spiritual practice and protective factor
Moral injury	Failure to distinguish moral injury from PTSD symptomology Lack of appreciation of spiritual aspects of moral injury	Exploring and augmenting self-worth, forgiveness and acceptance in relation with spiritual and moral traditions Using narrative framework to understand personal story Reframing MI as indicative of moral compass	Spiritual struggles and questions engaged within overall treatment Moral authority of chaplain/faith community utilized towards acceptance and forgiveness Communal connections enhanced

Table 1 (continued)

Presenting clinical issues	Reasons for spiritual domain underutilization	Themes of questions generated by chaplains	Clinical gains through integration of spiritual domain
Opioid use disorder	Misunderstanding of particular faith tradition due to cultural bias/blind spots Overreliance on medical model of addiction	Putting experience of judgement and shame in conversation with spiritual traditions Exploring identity of motherhood	Increased recovery capital including community support Spiritual resources to counteract messages of shame and guilt Increased treatment adherence through recognition and integration of spiritual tradition

Why the Spiritual Domain Might be Underutilized

Ironically, the nature of Andrew's clinical presentation often precludes a thorough utilization of the spiritual domain, as the religious or spiritual content he presents is often explained away as psychiatric symptomology. Exploration of these themes on their own terms is thought to be neutral at best, and possibly detrimental.

Relevant Research or Conceptual Work Informing a Spiritual Approach

Religion and spirituality have been shown to have both positive and negative roles in relation to coping with psychotic symptoms (Mohr et al., 2006). Parallel to other conversations that might stir discomfort, such as suicidality or substance use, simply avoiding discussion of religion due to the harm it might cause is counterproductive. Directly addressing and discussing Andrew's religious and spiritual affinities in a clinical context supports their utilization as sources of resilience and of coping (Gooding et al., 2019; Mohr, 2004; Mohr et al., 2006; Rosmarin et al., 2013). In addition, the content of religious delusions can be influenced by social environments and by family beliefs and attitudes (Sofou, 2021) and therefore are worth exploring rather than treating as random noise.

Questions Generated by Chaplains

Andrew's church tradition encourages prophetic witness and an active relationship with the Holy Spirit. Do these aspects of his family/cultural background have meaning for Andrew? What was his upbringing like in this family/church? Did he feel encouraged, supported? Was his voice heard? What has his religious or cultural background led him to understand about his illness?

What is Andrew's own sense of meaning and purpose? Given his many disempowered statuses, does he feel his own significance and worth? Is there an appropriate way for him to engage with his own spiritual traditions that might reinforce healthy self-esteem and instill self-worth? Rather than ***the*** messenger of God, might he be able to understand himself as ***a*** messenger?

In the face of a chaotic social environment, how does Andrew find a sense of control? How are potential/actual losses in functioning due to his schizophrenia impacting him? Can his spiritual resources help provide a sense of familiarity, reliability, and support?

What Would be Lost Without Engaging the Spiritual Domain

Without his spiritual beliefs being intentionally addressed, Andrew might feel a dichotomy between his religious identity and treatment adherence. Inclusion of the spiritual domain can positively impact Andrew's alliance with the treatment team (Mohr et al., 2006). Openness to and support around broader spiritual exploration, along with the team validating his religious faith, might allow Andrew to draw on his spiritual and religious beliefs as a source of strength, empowerment, and resiliency in coping with a difficult illness.

Clinical Area II: Depression and Grief During COVID-19

Sue is a 65-year-old widow who does not identify with any religious tradition. Her husband died of a heart attack in the early months of the COVID-19 pandemic. She was not able to be present at the time of his death because of hospital visitation policies at that time. Lately she has been spending almost all day in bed and is losing weight. Her son and grandchildren live nearby, but she has been declining opportunities to visit with them. On the phone, she will often tell her son that she wishes she could go and be with her husband.

Why the Spiritual Domain Might be Underutilized

Sue's lack of explicit identification with a religious tradition might lead to an omission of the spiritual domain when considering ways to understand and support her care. It might also be postulated that her grief can be attended to through the psychological or social domains, without invocation of the spiritual.

Relevant Research or Conceptual Work Informing a Spiritual Approach

Recent evidence has brought into question the assumption that people without an explicit religious identification do not desire or benefit from spiritually-integrated care (Rosmarin et al., 2021). This possibility is especially important to consider when caring for persons who are grieving.

While grief can exacerbate or cause mental health symptoms (Shear, 2012; APA, 2020), it should not be seen solely as a clinical or medical issue (Boelen et al., 2010; Friedman, 2012).

Questions Generated by Chaplains

What does Sue miss about her husband? How did they meet? What were some of the important or pivotal experiences they shared? What are some of the most precious memories she has of their time together? What does their relationship and life together mean to Sue?

What has been Sue's experience of the loss, especially under the circumstances described? What might Sue have preferred their last moments to have been like? What would she have liked to have said to him before he died? What was the impact of the loss of the time together at the very end of her husband's life? Has Sue been able to mourn, especially given the circumstances of the pandemic and the loss of availability of public gatherings (Mortazavi et al., 2021)? Might there be a need for ritual to be facilitated? Might body-centered practices (Doehring, 2019) help?

How can Sue reinvest in the hope and goodness of life? How does she experience her relationship to her husband in a transcendent manner—is there a connection to her that endures past life and death? What is his legacy? Does her desire to "be with her husband" indicate a sense of yearning for connection? What might make her feel close to him in this life? How might his presence be experienced and connection to him invoked?

What Would be Lost Without Engaging the Spiritual Domain

Although empirical evidence does not yet clearly show correlation between religion/spirituality and positive health outcomes, we do know that a majority of bereaved persons think that religion and/or spirituality is helpful to them as they adjust to loss (Wortmann & Park, 2008). Moreover, while other disciplines have tools and resources to respond to grief, there are unique opportunities that arise when the spiritual domain is engaged. For example, a psychiatric accounting of grief tends to acknowledge the challenges of grief in relation to mental health, i.e., grief as something to cope with and manage. But it may fail to understand grief as a vital aspect of human life, as a gift, as offering opportunity for growth, as the "ballast for the two great accumulations of wisdom and compassion" (Park & Halifax, 2021). Grief can operate as a metaphorical booster shot for life: reminding us of our love, our embeddedness, our dependencies, and the preciousness of being alive.

The COVID-19 pandemic appears to be receding in its intensity, leaving in its wake incredible amounts of grief and loss (Wallace et al., 2020). Part of the healing process, on individual and cultural levels, may involve finding ritual and soulful practices related to these experiences of death and loss – a need which is not simply relegated to those who identify as religious (ter Kuile, 2020).

Clinical Area III: Demoralization and Suicidality

Jeanne is a 35-year-old Veteran with post-traumatic stress disorder (PTSD) and borderline personality disorder resulting from severe childhood and military sexual trauma. She has tried a variety of treatments for her PTSD including cognitive processing therapy (CPT) and Eye Movement Desensitization and Reprocessing (EMDR) but reports that they are not helping. She describes feeling hopeless and helpless—and says that if there is nothing that can be done to alleviate the suffering she is experiencing, she might as well end her life. She says that if she kills herself, she will go to hell, but that the life she is living is also hell.

Why the Spiritual Domain Might be Underutilized

Jeanne's sense of suicide as morally wrong and/or linked to eternal punishment might be serving as a protective factor and inhibiting the actualizing of her ideation into suicidal behavior. However, this protective factor is left alone in its basic conceptualization, without exploring additional theological or spiritual values that might underlie and even augment its protectiveness. Perhaps there is fear that talking about the protective factor might disturb it—a fear which, as we noted earlier, is unfounded.

Relevant Research or Conceptual Work Informing a Spiritual Approach

While a belief in suicide as immoral has been shown to be protective against suicidal ideation, even greater protectiveness is found among people who also consider themselves religious and/or attend religious services (Hameed et al., 2020). This is not the case when a religious tradition causes internal conflict—for example LGBT youth raised in religious environments have a higher rate of suicidality, presumably due to exposure to religious condemnations of types of sexual orientation or gender identities (Gibbs & Goldbach, 2015). But a spiritual or religious identity that instills acceptance, hope, and belonging may very well be more protective than one that simply cautions avoidance of divine punishment.

Relatedly, demoralization, usually characterized by a sense of hopelessness and helplessness, is increasingly recognized as relevant to psychiatric care (Clarke & Kissane, 2002) and as correlating with suicidal ideation (Costanza et al., 2020a, 2020b). Demoralization is distinct from clinical depression (Murri et al., 2020) and, like grief, can be seen as rooted in the territory of human response or experience rather than a pathological clinical issue (Slavney, 1999; Figueiredo, 2013).

Questions Generated by Chaplains

What is it like for Jeanne to be stuck between two "hells" and the weariness of trying so many treatments to no avail? How can we validate and recognize her pain and despair? What gives her relief or freedom? What are the religious or spiritual understandings informing her sense of hell? Beyond a sense of avoidance of divine punishment, is there a positive version of this message, i.e., that there may be a purpose or plan for her life? If her theological understandings include God, how does God invite her to freedom/hope/relief? Does she understand God as present with her in her struggles and weariness?

What does hope look like for Jeanne? Is hope related to direct foreseeable outcomes, or is she open to the premise that there may be goodness ahead even if it cannot fully be seen or imagined (Lear, 2006)? In what ways is Jeanne's pessimism serving her, and what might happen if she were to allow openness to an unknown future? What does Jeanne possess in her background, understandings, and sources of resilience and strength that might serve as resources for hope practices?

What Would be Lost Without Engaging the Spiritual Domain

Exploring the spirituality which informs Jeanne's beliefs might allow for the engagement of strength-based protective measures (Allen et al., 2021). In other words, rather than just invoking a spiritual maxim as a deterrent, spirituality can yield resources for wellness, positive growth, and hope. Similar to the demoralization it seeks to counteract, hope is a concept that relates to the human spirit. While it can be sought to be measured and/or employed within a psychological domain (Griffith,

2018; Snyder et al., 1996), limiting it or its effects to the psychological misses the importance of hope as a spiritual practice (Hardies, 2016).

Clinical Area IV: Moral Injury

Robert is a 45-year-old Veteran who has recently been discharged from the military due to his PTSD. A member of the Special Forces, he was deployed 13 times over 10 years before being told he could no longer continue. Robert is struggling with the transition to civilian life, with his relationship with his ex-wife, and with figuring out how to structure his days. He has a strong sense that he has "failed" by being unable to care for his military unit. He wonders whether he is "unforgivable." He is not sleeping well due to nightmares and his drinking has increased. Robert belongs to a faith community but feels like he has a hard time connecting with other people when he is there.

Why the Spiritual Domain Might be Underutilized

The spiritual domain can be overlooked due to two clinical omissions. The first would be to recognize Robert's PTSD but fail to see that he is also suffering from moral injury. Moral injury may be co-occurring but is clinically distinct from PTSD (Griffin et al., 2019); standard treatments for PTSD may not identify or specifically treat moral injury (Borges et al., 2020). The second omission would be to overlook the spiritual domain in the treatment of moral injury. Although moral injury has medical, psychological, or emotional components, moral injury often involves significant spiritual struggle or distress (Carey & Hodgson, 2018), and may be even categorized as a form of spiritual injury in and of itself (Brémault-Phillips et al., 2019; Brock & Lettini, 2012).

Relevant Research or Conceptual Work Informing a Spiritual Approach

Moral injury may emerge when one participates in or witnesses events that go against one's personal moral code or core beliefs (Litz et al., 2009). Experiencing such events heightens risk for mental health concerns including depression (Currier et al., 2015), PTSD (Bryan et al., 2018), and suicidal ideation and behavior (Nichter et al., 2021). Moral injury symptomology (inappropriate shame/guilt, lack of self-esteem, struggles with forgiveness, loss of meaning-making or values) often relates to conflicts with global meaning systems, thus rendering utilization of the spiritual domain highly relevant in many of these cases.

On a basic level, the spiritual domain may be utilized to help understand and explore a patient's religious belief systems and moral values, including those encountered from their cultural milieu or family upbringings. For example, issues around forgiveness can be a presenting symptom of moral injury (Kopacz et al., 2016) and may be impacted by cultural and religious values. Beyond that, the spiritual domain may help illuminate moral injury's impact on a person's meaning-making and sense of place in the world. In one study, moral injury was found to be

associative to higher suicidal ideation through a lower presence of meaning in life (Kelley et al., 2021). This finding connects to earlier research noting links between Veterans' motivation for mental health services and their guilt/weakening of religious faith and concluding that "a primary motivation of veteran's continuing pursuit of treatment may be their search for a meaning and purpose to their traumatic experiences" (Fontana & Rosenheck, 2004).

Other studies have understood moral injury using a psycho-spiritual developmental lens (Harris et al., 2015; Usset et al., 2020), leading to the design of spiritually-integrated interventions intended to increase tolerance of ambivalence, mystery, and complexity (Usset et al., 2021). Finally, moral injury calls for a communal and collective response (Brock & Lettini, 2012) in which the moral authority of chaplains and faith leaders can be employed towards helpful theological reframing and by modeling acceptance and belonging (Nieuwsma et al., 2021).

Questions Generated by Chaplains

Can we help Robert explore his sense of himself as "unforgivable"? To what or whom does forgiveness relate? Are there any religious or spiritual understandings that inform his conceptions around forgiveness? And if so, are there resources within those traditions which might provide guidance and healing? Can we model forgiveness with Robert?

Are there other moral or literary concepts that Robert could utilize to understand his story, such as Campbell's Hero's Journey (Lawson, 2005)? How has his journey changed him? Is he grieving losses, including the loss of who he was? What is Robert's sense of himself as one who cares for others? Can that same sense of care be invoked towards and inclusive of self?

Is Robert's faith capable of accommodating doubt, ambiguity, complexity? Are there resources in his faith tradition and/or sense of meaning making that might be more helpfully engaged? What is his sense of belonging? Can he experience his faith community as big enough to hold him when he is struggling?

Lastly, how does Robert understand his struggles? Does he see them as a sign of weakness, or being unfit, or rather as a "testimony to [his] resilience of conscience and to [his] basic goodness" (Brock & Lettini, 2012)?

What Would be Lost Without Engaging the Spiritual Domain

Not all persons experiencing moral injury will do so through the lens of religion or spirituality, but for the many that do, engagement of the spiritual domain becomes an important part of treatment (Currier et al., 2021). For example, Nieuwsma et al. (2021) discuss a therapeutic situation in which the patient successfully met the benchmarks for termination but was left with unresolved spiritual distress. Nieuwsma et al. describe: "[the patient] and her therapist had systematically tackled [her] thoughts, feelings, and behaviors effectively, yet there was something else, something 'other' that [she] could not explain" (p. 251). In this clinician encounter and others like it, engagement of the spiritual domain was an essential component of holistic care.

Clinical Area V: Opioid Use Disorder

Sarah is a 35-year-old Reform Jewish woman who struggles with an opioid use disorder. She is divorced and the mother of three children under the age of 10. She attends synagogue only at the Jewish New Year but celebrates home observances. Several months back, custody hearings were initiated by her ex-husband who was concerned that their children were being exposed to illicit substances. More recently, she failed a drug test during these hearings, and lost custody of her children. She feels deeply ashamed of her use and its impact on her ability to be a good mother to her kids. She speaks angrily about feeling "judged" by everyone.

Why the Spiritual Domain Might be Underutilized

An assessment overly influenced by secular or Christian cultural practice may assume that a faith connection is not relevant to Sarah since she does not regularly attend services. This view might miss that for many Liberal Jews and Jewish women in particular, home-based observances are a key backbone and expression of their faith belonging.

Relevant Research or Conceptual Work Informing a Spiritual Approach

Waters (2019), a pastoral theologian, makes the case that addiction is a "soul-sickness", an emergent condition that takes over the will and spirit. Treatment requires spiritual bulwarking as well as a holding on to hope and humanity of the person battling the chronic condition. Spirituality has long been a component of 12-step approaches to addiction recovery, a treatment modality with a long history of anecdotal evidence more recently confirmed by research (Kelly et al., 2020). The integration of spirituality within addiction treatment beyond the 12-step tradition is a relevant enterprise (see, Earl et al., 2019) given that 12-step models do not work for everyone. For example, if someone like Sarah were to encounter a 12-step program that was overly identified with a Christian tradition (i.e., included elements like the Lord's Prayer) this might create dissonance with her Jewish identity. For Sarah, it might be important to find other ways to engage her religious and cultural traditions. Any treatment approach with Sarah should account for the higher rates of shame and depression among women in recovery from addiction (O'Connor et al., 1994).

Questions Generated by Chaplains

Can we interrogate and further understand the judgement Sarah describes? Are they related to her cultural and religious understandings, for example, Jewish sensibilities surrounding practical and exemplary living? Does Sarah experience her religious community as offering acceptance or judgement? What does supportive community look like for her?

Relatedly, where does Sarah feel shame and self-judgement? Is this shame intensified around her perceptions of motherhood? Can her theological and spiritual traditions, i.e., Judaism's yearly process of atonement lead to compassion, acceptance,

and even reevaluation of what it means to be a good mother? How can her feelings of grief and hurt be utilized as a resource for positive responsibility and motivation towards recovery rather than towards shame and stagnation?

What Would be Lost Without Engaging the Spiritual Domain

The difference between the inclusion or exclusion of this domain then, comes down to whether we can give Sarah as many tools and resources as possible in her recovery from this chronic disease. Enhancing Sarah's spiritual orientation can serve as "recovery capital" and can enhance ability to sustain remittance from substance use disorders (Galanter et al., 2021). This might mean that Sarah could connect to recovery resources in her own religious community (see for example jewishboard.org/listing/jacs-jcsrecovery; Jury, 2021). It might also mean that she can access theological traditions and experiences of community belonging to counteract messages of shame and guilt.

Limitations and Discussion

These case studies are intended to illustrate what engagement with the spiritual domain might look like in five different clinical scenarios. These are composite cases formulated by chaplains, rather than clinical data gathered through patient consent or chart review. We do not purport to have proof of direct causal connection to any specific clinical outcomes, nor do we even suggest definitive models of how the spiritual domain is engaged. Moreover, given the ways that these case studies emerged from our particular clinical practices, the data presented here is not intended to represent definitive or complete examples of spiritual care. For example, we come primarily from Jewish and Christian faith traditions, and our perspectives are limited by this background. Our backgrounds and vocations also mean that we have a personal and professional stake in arguing for spirituality's relevance.

Our work here clearly illustrates the need for continuing research related to spiritual interventions as well as feasibility and implementation studies related to models of providing such care. Undertaking such research is complex. Sulmasy, even as he introduces and argues for the importance of the inclusion of the spiritual domain, reminds us that: "one can only measure what can be measured" (2002, p. 27). Nieuwsma notes that there may be a range of outcomes beyond what are typically measured in healthcare, for example "whether a person is living a life in accordance with his or her values" (2016, p. 9). Given challenges around methodologies and concerns about fundamental incongruences of spiritual care as a scientific discipline, questions have been raised as to whether it is even possible to have an evidence-based modality of spiritual care (O'Connor, 2002; VandeCreek, 2003).

Nonetheless, practitioners of spiritual care and of mental health continue to see the value of collaborative and integrative work, and both fields increasingly understand the importance of being informed by evidence and scientific study. The clinical examples in this paper represent clinical practice with emerging yet incomplete evidence for the value of engaging the spiritual domain. In lieu of complete evidence,

we argue that we should take our cues from what we know about the continuing pervasive presence of religion and spirituality over time and place, and from the ways in which they provide comfort and meaning especially in the midst of human suffering and challenges (Park et al., 2013).

Conclusion

Engel introduced the biopsychosocial model as a corrective to the biomedical approach, which can focus too exclusively on fixing or curing problematic symptoms rather than caring for a person's whole health. Sulmasy enlarged that model, reminding us that the spiritual is an important dimension of understanding patients as whole persons. The continued development and integration of the spiritual domain into mental health can only enrich our understanding of human nature and add depth and sensitivity to our attempts to respond to human suffering.

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Declarations

Conflict of Interest The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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