

# Mental Health and Spirituality

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## Introduction

The historical divide between religion and science has had profound implications for the world we live in, culminating in a twentieth century culture modelled on a mechanistic, Newtonian paradigm of reality. Yet there need be no such enduring split, for advances in quantum physics, which are profoundly changing our thinking about the universe and the nature of reality, bring an opportunity to reconcile science and spirituality in ways that could not have been imagined a hundred years ago.<sup>1,2,3</sup>

It was timely, therefore, that at the turn of this century the Spirituality and Psychiatry Special Interest Group in the Royal College of Psychiatrists was founded. In launching the group, we have been indebted to the late David Larson. Professor Larson was a leading American researcher in the field of health and spirituality and over the previous decade published an enormous amount of data on the healthcare benefits of spirituality. Consequently, and with the support of the John Templeton Foundation, modules on spirituality have been introduced in over 100 US medical schools. In this country we have just one to date, pioneered by John Swinton<sup>4</sup> at Aberdeen University. Swinton's work has been groundbreaking in the UK and a key objective of our Group is to support this kind of development in other medical schools.

Another principle aim is to inform the content of the training curriculum for psychiatry in the UK, and the range of clinical skills acquired. The problem here is that psychiatrists are not given any guidance about how to handle spiritual matters when they arise in the consultation and because they feel unskilled, the tendency is to gloss over such matters. Yet we know from service-user surveys that a great many people going through acute mental distress turn to their spiritual and religious beliefs to help them cope.<sup>5</sup>

## The Context of Mental Illness

The scale of the global challenge posed by mental illness has been highlighted by several recent studies.<sup>6,7,8</sup> About one in ten adults (450 million worldwide) is affected, accounting for over 12% of the global burden of disease and rising. In Europe and the Americas, the burden of mental illness is over 40% of the total burden of disability. What can this epidemic mean?

Psychiatry, the study and treatment of mental illness, has developed in the West as a specialty of medicine and like most of Western medicine it is wedded to the paradigm of the body as a marvellous kind of machine, under the direction of the brain. The neural activity of the brain is thought to generate consciousness, while emotional stresses have their impact by directly influencing brain chemistry. Since all mental function is considered to be a product of brain chemistry, it follows that what we call the mind is produced the brain.

Such a view has no place for the metaphysical soul. Before each of us was born, there was nothing, and when we die, consciousness is snuffed out

forever. This does not preclude a spirituality based on the desire to do good and to act with compassion (and who does not reflect at some time on the majesty and mystery of the cosmos?) But the mechanistic worldview sees each human being like a little ant, wandering on to a gigantic stage set. Who constructed the stage set is a puzzle for which the culture of modern science has no answer.

The greatest minds have always known better than to be limited by such material realism. For instance, Isaac Newton himself described his method as mystical intuition or insight into implicate truth, which he then used mathematics to validate. *'Truth', said Newton, 'is the offspring of silent, unbroken meditation'*. For Newton, there was no schism between the spiritual and physical universe; he believed that the physical world had been created by, and was a profound testimony to, the hand of God. Rene Descartes, who has been unjustly accused of being a materialist, had a deep belief in the workings of the Divine. And Albert Einstein once famously remarked, 'God does not play dice'.

It is no use blaming science for the physicalist interpretation of the universe. Science is nothing but a tool, a means of gathering knowledge according to the capacity and limitations of the instrument used. Unfortunately, as spiritual values have receded under the onslaught of consumer-led materialism, scientific technology has become the new God. It is a God who always tantalizes and never fulfils.

Take, for example, that extraordinary statistic of mental illness as now contributing 40% of the burden of disability in Europe and the Americas. Where else should that fundamental loss of meaning and purpose in life go except to the psychiatrist's consulting room when for many people the established faiths seem to be so divorced from the realities of daily life? To call every situational crisis a spiritual one would be misguided. Yet beneath the difficulties relating to parents, families, children and the workplace, there is often a painful lack of, and searching for, core spiritual values. Sometimes it takes a breakdown to find them.

In fact, the majority of people coping with mental disorder do find themselves turning to their spiritual and religious beliefs to help them pull through. For instance, in one survey of psychiatric patients, over half went to religious services and prayed daily, and over 80% felt that their spiritual beliefs had a positive impact on their illness, providing comfort and feeling of being cared for and not alone. Yet over a third of them did not feel able to discuss such things with their psychiatrists.<sup>9</sup> Perhaps their intuition was spot on, for other research shows that whereas in the general population over 80% have belief in God or a higher power, around only a third of psychiatrists and psychologists hold such beliefs.<sup>10</sup> (The danger here is that psychiatrists may think they represent the norm, when it is they who are atypical in this regard).

### **Empirical Research into Spirituality and Health**

Health, according to the World Health Organisation's constitution, is *'a state of complete physical, mental and social well-being, not merely the absence of disease'*. The WHO report continues: *'the health professions have largely followed a medical model, which seeks to treat patients by focusing on medicines and surgery, and gives less importance to beliefs and to faith – in healing, in the physician and in the doctor-patient relationship. This*

*reductionism or mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realise the value of elements such as faith, hope and compassion in the healing process*.<sup>11</sup>

The healing process applies to mental and physical afflictions alike. In 2001, a seminal publication, *The Handbook of Religion and Health*, was published.<sup>12</sup> This was the culmination of a decade's work by Harold Koenig, Michael McCullough and David Larson, looking into the relationship between religion/spirituality and a wide range of physical and mental health conditions, covering more than 1200 studies and 400 research reviews. A sixty to eighty per cent correlation between religion or spirituality and better health was found in the areas of prevention, recovery and coping ability in a wide range of conditions, including high blood pressure, cerebro-vascular disease, heart disease (including substantially increased survival in the elderly after heart surgery), immune system dysfunction (increased survival time in AIDS patients), improved coping with cancer (in one study, 93% of cancer patients said that their religious lives helped sustain their hopes), in living with pain and disability, and smoking prevention. Not least, there is a striking correlation with longevity. One longitudinal study of over 21,000 US adults has shown that after controlling for other factors, attending religious services more than once weekly increased the lifespan by an average of 7 years for whites and 14 years for African Americans.<sup>13</sup>

Many of these areas of research have been based on standard research methodology, using controlled trials and statistical data analysis. A good example has been the effect of intercessory prayer on patients in intensive care units, a double-blind trial that yielded a statistically significant result (the prayed-for group of patients recovered with fewer complications).<sup>14,15</sup>

### **Cure versus Healing**

It is gratifying to find such positive correlations between spirituality and health. But they overlie a deeper conceptual problem regarding spirituality in medicine that I now want to highlight. I referred earlier to the paradigm of the body as a machine. This arises from the concept of the universe as mechanical, a worldview that began three hundred years ago and still holds sway. It is true that when bodily functions break down, symptom clusters emerge which indicate the dysfunction of certain components, rather like a car engine developing a fault. The paradigm of cure comes from this way of looking at things, and in some cases is readily applicable. Surgical interventions fit the model best - an arthritic hip can be replaced, the aorta patched, a liver transplanted. All of this nicely fits with the 'disease' model.

The same disease model is applied by psychiatrists to mental disorders on the basis that neurological, genetic or biological factors must lie at the heart of the problem. By correcting these factors, there is always the possibility of cure.

The disease model has served western medicine well. For instance, with chemotherapy, many cases of childhood leukaemia can be cured. Yet it has to be admitted that in adulthood, and increasingly with the passing years, most diseases resist cure. Drug treatments generally have side effects and a metal hip joint is not the same as one made of bone. Yet the word cure has a

magical ring to it, often used to depict an idealisation of health based on fear of death. Cure is a magic wand to wave in a culture that believes life ends with death. Such a prospect is unbearable and so all kinds of heroic medical interventions are sanctioned, hence the quip 'the operation was successful but the patient died'. This uncomfortably reminds us that it is always a person who is suffering from the cancer, the arthritis or the liver failure. The person is not the disease, just as the driver is not the car.

When we talk of illness as opposed to disease, we are describing the response of that person to a disease process, a response that varies enormously according to temperament, circumstance and the emotional attitude held by the individual. Take the avoidance of pain, for example, which is fostered by pharmaceutical companies promoting popular analgesics. Rather than attacking the headache with a painkiller, (note the aggression in the very word painkiller), it would be much better to ask oneself why the headache has come on. It is only too often due to fatigue or stress, an urgent plea by the body for respite!<sup>16</sup> Responding to this plea will relieve the symptom, though it may take a bit longer. The headache will pass, but the mechanism is entirely different, for the body has been encouraged to heal.

The essential point to make about healing is that the process concerns wholeness (the root of the word wholeness comes from 'Hal', 'hel', or 'heil' in Saxon, high German or old Norse, meaning none other than health or healing).<sup>17</sup> This calls for a new focus, moving from the mechanistic model of parts of the system breaking down in isolation to the holistic approach of seeing the self as arising from an intimate relationship of mind, body and spirit. Nor can the self be taken in isolation; it has to be understood as a social reality, one that places and delineates each person in a matrix of relationships.<sup>2</sup>

From this holistic perspective, the term disease is best confined to meaning just that: dis-ease, a lack of harmony or balance within the human being. Healing, therefore, has to address the whole organism, from micro-cellular structures through to organ-specific functions. We now know from research in psychoneuroimmunology (PNI) that thoughts and feelings profoundly influence our physiology. Nor is this a one-way system, for with feedback loops abounding at every level, the psyche-soma is in a state of constant equilibrium, with both internal and external worlds.

### **Holism and research**

I mention PNI in particular, for this relatively new area of investigation promises a revolution in medicine over the next 100 years.<sup>18</sup> For example, research has shown that stress depresses immune function, whereas a person's religious/spiritual beliefs will protect their immune functioning. For instance, recent laboratory findings include:

- A rise in salivary IgA levels (a marker of immune function) in students watching a film of Mother Teresa, compared with students watching a war film<sup>19</sup>
- The levels of serum IL-6 (interleukin-6) in subjects regularly attending religious services is nearly 50% lower than in non-attendees. (IL-6 is a powerful mediator of the inflammatory response)<sup>20</sup>
- In a study on HIV positive gay men, spiritual and religious practices and beliefs were associated with higher CD4+ counts (lymphocytes -

specific white cells - active in mounting the immune response) than in the control group. On the other hand, high stress levels increase the progression of the disease fourfold<sup>21</sup>

- In a study of women with breast cancer, the importance of religious or spiritual expression correlated positively with natural killer cell numbers (active against tumours and infective microbes), T-helper cell counts and total lymphocyte activity<sup>22</sup>

In clinical practice, stress has been shown to be linked with the occurrence of respiratory infections, 'flu, cold sores<sup>23</sup>, delayed wound healing<sup>24</sup>, psoriasis, overactive thyroid function, diabetes, rheumatoid arthritis and relapse in Multiple Sclerosis.<sup>25</sup> Additionally, in the mental health field, where stress is common to every kind of breakdown, the extraordinary protective effects of religion and spirituality are now just beginning to be recognised. For example:<sup>26</sup>

- *Depression.* Overall, some 25% of women and 12% of men suffer major depressive disorder during their lifetime. But people with a spiritual or religious affiliation are up to 40% less likely to get depressed than those who don't have such an affiliation. And when they do get depressed, they recover faster. Where psychotherapy is offered, those receiving religiously orientated therapy sensitive to their religious beliefs score best on post-treatment measures<sup>27</sup>
- *Depression among the medically seriously ill.* Depression affects up to 35% of this group of patients. One study using multidimensional measures showed that for every 10-point increase in the intrinsic religion score, there was a 70% increase in the speed of remission from depression.<sup>28</sup> Another study showed that the more severe the disability, the stronger the protective effect of religious commitment<sup>29</sup>
- *Suicide.* Adults aged over 50 who have never participated in religious activities are four times more likely to commit suicide than those who do. This holds true after having adjusted for other variables.<sup>30</sup> Similarly, religious commitment among teenagers significantly reduces the risk of suicide<sup>31</sup>
- *Substance Abuse.* Religious/spiritual commitment correlates with lower levels of substance abuse. The risk of alcohol dependency is 60% greater when there is no religious affiliation.<sup>32</sup> In one study of opiate withdrawal, 45% of participants in a religiously orientated programme remained drug-free at one year compared with 5% in a non-religious treatment programme.<sup>33</sup> Concerning alcohol abuse, those who participate in AA, which is spiritually orientated and invokes the help of a Higher Power, are most likely to remain abstinent after inpatient or outpatient treatment.<sup>34</sup>

Studies such as these surely tell us that there is far more to the pathogenesis of mental illness than the biological sciences can ever account for.

### **Diagnostic Considerations**

Since most mental illnesses have no identifiable organic basis, we tend

to avoid calling them diseases. Yet, in the expectation that perhaps one day the cause will be pinpointed, we have an immensely complex system of diagnosis, which is firmly rooted in medicine. The manual used worldwide, the International Classification of Mental and Behavioural Disorders, was begun by WHO in the 1960's and which has been refined many times since.<sup>35</sup>

Arriving at a diagnosis is important when it reliably indicates the prognosis and points to an appropriate tried and tested treatment. (After all, the throughput of a black box can be described without knowing what is inside). But the danger here is that these diagnoses continually reinforce the disease model, which goes hand in hand with treatments being developed by the multinational pharmaceutical industry. It is hardly surprising that the concept of healing has not had much of a look-in.

Within the profession, psychiatrists agree that while there is a place for psychological treatments in many disorders, the two most serious illnesses, schizophrenia and manic-depressive disorder do frequently require a pharmaceutical treatment approach. Misdiagnosis can lead to tragic outcomes in both conditions and making a diagnosis based on clear operational definitions is important. Yet this indebtedness to the medical model raises as many problems as it solves. Take the following category from ICD-10, under the heading F23.0 (Acute polymorphic psychotic disorder without symptoms of schizophrenia). To quote, *'hallucinations, delusions and perceptual disturbances are obvious but markedly variable, changing form day to day or even from hour to hour. Emotional turmoil, with intense transient feelings of happiness and ecstasy or anxieties and irritability is also frequently present. This disorder is likely to have an abrupt onset and rapid resolution of symptoms; in a large proportion of cases there is no obvious precipitation cause'*.

Compare this with schizophrenia (F20) and you find that the picture is much the same, except that for schizophrenia, symptoms have to have been present for more than one month and have a pattern of consistency about them – a less labile and more fixed clinical picture.

This example illustrates how an illness like schizophrenia, which often turns out to have lifelong consequences, may arise from an acute disturbance bearing all the hallmarks of a psycho-spiritual emergency. I am not saying that schizophrenia is the result of an untreated spiritual crisis. Research suggests that there is a vulnerability to schizophrenia that has multiple factors: genetic, traumatic, neuro-developmental, nutritional, as well as psychological. But we simply have no idea how many people might be prevented from progressing to schizophrenia with the right kind of psychospiritual intervention.

Professor Stanislav Grof<sup>36</sup> worked extensively in this area and it is clear that the management of a full-blown spiritual emergency is a round-the-clock task, with skilled input over days and sometimes weeks. Regrettably, to my knowledge there is currently no treatment resource in the US or the UK where such facilities are available. People either have the good fortune to recover or end up diagnosed with schizophrenia.

Beyond the bounds of orthodox psychiatry, and yet well established in the US and gaining ground in the UK, is the therapeutic method known as 'spirit release'. Take, for example, the work of the Nowotny Foundation. Dr. Karl Nowotny was a well-known Viennese psychiatrist who died in 1965. His subsequent communications to healers through the agency of automatic

writing indicate that from his post-mortem perspective in 'the fourth dimension' Novotny regards many acute schizophreniform illnesses as being caused by 'spirit attachment'.<sup>37</sup> Nowotny advises that all the patient's resources have to be mustered right at the outset, so that the negative influences can be resisted with a determined act of will, coupled with the help of Nowotny and his team in the spirit world. Equally important is the psychospiritual educational programme that immediately needs putting into place in order to protect against further psychic attack. Nowotny warns that if the attachment is allowed to persist, the erosion of personal will and the subsequent disintegration of personality makes it increasingly hard to address at a later date.

In the UK, The Spirit Release Foundation,<sup>38</sup> chaired by Dr. Alan Sanderson, a member of the Royal College of Psychiatrists, has brought together many practitioners in the field. Many are 'intuitives' who use clairvoyance or clairsentience. Others employ the interactive approach advocated by Edith Fiore<sup>39</sup>, Bill Baldwin et al.<sup>40,41</sup>, which enables what is, in effect, a psychotherapeutic encounter with the attached spirit through the agency of the patient.<sup>42</sup>

What kind of interface might such work have with orthodox psychiatry? Let us turn again to ICD-10, this time to the entry for trance and possession disorders (F44.3). These are classified as disorders in which *'there is a temporary loss of both the sense of personal identity and full awareness of the surroundings; in some instances the individual acts as if taken over by another personality, spirit, deity or 'force'. Attention and awareness may be limited to, or concentrated upon only one or two aspects of the immediate environment, and there is often a limited but repeated set of movements, postures and utterances'*. ICD-10 goes on to say that only trance disorders that are involuntary or unwanted, and which intrude into ordinary activities by occurring outside (or being a prolongation of) religious or other culturally accepted situations should be included here.

This is a fair point to make but leaves open to question whether factors of social convenience should be used to define pathology. Many mediums initially resisted their calling because they realised it would turn their lives upside down!

A further issue is that trance states occurring in the presence of other conditions are regarded as abnormal, for instance, after head injury, epilepsy or in conjunction with schizophrenic or manic-depressive disorder. Yet the onset of extra-sensory perception after a head injury, for instance, has been well documented. One of the leading participants in the US military 'Stargate' remote viewing programme, David Morehouse, began his work after being struck in the head by a bullet.<sup>43</sup>

For people with such capacities, seeing a psychiatrist carries the risk that their psychic abilities, if disclosed, will be seen as a feature of illness. Yet psychiatrists are trying to do a very difficult job and living with the constant awareness that their patients may do harm to themselves or others. They dare not take risks with their patients, for in the event of a critical incident the judgement of society comes down on them like a ton of bricks. It is hardly surprising that in upholding the mores of society on the one hand while adhering to the prevailing science of material realism on the other, psychiatrists publicly steer clear of topics like extra-sensory perception, in

public at least.

### **Spiritual Skills**

Privately, a good many psychiatrists do witness events that leave them wondering about the further reaches of consciousness. But even with colleagues, psychiatrists hesitate to speak about such things because they cannot be accommodated within the model of mind on which so much psychiatry is founded. From the outset, therefore, we have made it our house rule in the Spirituality and Psychiatry Special Interest Group to listen respectfully and without censure to each other's opinions and experiences, and to encourage everyone to speak from the heart. We understand the need to talk the language of ICD-10 within the profession at large; it is the lingua franca and necessary for everyday clinical practice. But in the meetings of the Special Interest Group, we place diagnosis within a larger frame of reference, the belief that there is a guiding principle, a higher power (which some call God), which accompanies the lives of our patients' and ourselves. Sometimes this awareness is implicit in the psychiatric consultation. Other times, if we are on the lookout, we find that our patients want and need to talk about it.<sup>44</sup>

As clinicians we should be always concerned to relieve suffering whenever we can. My understanding of suffering is that it is the experience of pain, mental or physical when it seems to be without meaning or purpose. Bringing the bigger picture into the consultation opens up the possibility of looking at all of this in new way. It is important to work within the framework of a person's beliefs if they belong to an established faith tradition, but sometimes the discovery is spontaneous, intuitive and made right there in the consulting room.

The key to working in this way is extraordinarily simple. It requires only that the psychiatrist shows genuine interest in, and respect for, what ever the patient ventures to confide.<sup>45</sup> One person's subjective reality is no less and no more valid than another's. They all serve the same purpose – to give meaning to life. It is true that there can be enormous problems when one person's reality badly clashes with consensus (or popular) reality. Believing yourself to be Jesus doesn't mean that you are going to be able to walk on water - you could well drown. At the same time, current research into the whole world of paranormal phenomena <sup>46</sup> is turning what was previously regarded as apocryphal into hard scientific data, so we should always keep an open mind.

The task for the psychiatrist, therefore, is not to assert the supremacy of his or her own worldview, but to help the patient find a way to live in, and with, the world, even when the patient's beliefs and values might appear to outsiders to be highly idiosyncratic. Such beliefs, sometimes classed as delusions, can be explored in terms of hopes and fears that have a universality of meaning. What is life for, the problem of good and evil, why must we suffer, what happens when we die? Such fundamental questions tend to get pushed aside by the pressures of everyday life. But when someone has a breakdown, these questions loom large and if the psychiatrist is not afraid to enter into the dialogue, a deep contact is made. This can be crucial if a breakdown is to have the chance of turning into a breakthrough.

The next task is to get spirituality on the agenda for psychiatrists in training in the UK. and to make spiritual enquiry as relevant as taking a family or social history. The Special Interest Group has put forward a detailed

submission to the Royal College of Psychiatrists for a forthcoming revision of the curriculum for the MRCPsych examination. Here is a summary of what we are proposing.<sup>47</sup>

### *Historical perspective*

The psychiatrist should be able to demonstrate awareness of, and sensitivity to, the interface of spirituality/religion and psychiatric practice with reference to its historical development and current status

### *Spiritual aspects of clinical work and associated teaching*

The psychiatrist should be able to demonstrate awareness of spiritual aspects of psychiatry arising from:

- The need to find a sense of meaning and purpose in life
- The personal search for answers to deeper questions concerning birth, life and death
- The difference between spirituality and religion, and their inter-relatedness
- The relationship of spirituality to the development and expression of individual human values
- How spirituality informs concepts of good and evil

The psychiatrist should be able to demonstrate a working knowledge of:

- Spiritual crises, meditation, prayer and altered states of consciousness, including Near Death Experiences (NDEs)
- The spiritual significance of anxiety, doubt, guilt and shame
- The spiritual importance of love, altruism and forgiveness, and their relation to mental health
- The influence of materialistic goals on personal identity and self-esteem
- The reciprocal relationship between culture and spiritual/religious beliefs and practices, and the consequences for psychiatric practice
- How to take a spiritual history from a patient
- How the presence or absence of spiritual/religious beliefs and practices in mental healthcare workers may influence clinical decision-making
- The role in clinical management of spiritual/religious support networks, including chaplaincy and pastoral care departments as well as those in the community

### *Research*

The psychiatrist should be able to demonstrate familiarity with:

- The application of both quantitative and qualitative research to the field of spirituality and psychiatric practice
- The findings of epidemiological studies relating spirituality to mental health variables
- The introduction of spiritual values in the design and execution of research

- Validated instruments for measuring spiritual and religious beliefs
- The contribution of research to understanding the neuro-physiology and efficacy of prayer, meditation, forgiveness and love

### *Spiritual attitudes and values*

The psychiatrist should be able to demonstrate:

- Awareness that good medical practice is founded on values which include discernment, compassion, generosity, tolerance, patience, honesty, humility and wisdom
- Awareness of how his/her own value systems may impact on others
- Sensitivity to, and tolerance of, the value systems of others
- An understanding of the concept of spiritual development as part of personal growth

### *Clinical skills based on spiritual values*

The psychiatrist should be able to demonstrate competence in:

- Being able to stay mentally focused in the present, remaining alert and attentive with equanimity
- Developing the capacity to witness and endure distress while sustaining an attitude of hope
- The recognition of his/her own counter-transference responses to spiritual disclosures
- Honest self-appraisal, in the interests of continuing personal development
- Maintaining personal well-being in the interests of patient care

### **Healing and Healthcare**

Spiritual awareness needs to be a cornerstone of psychiatry<sup>48</sup>. In addition to the biological, social and psychological aspects of mental health care, the spiritual dimension above all brings the prospect of healing. Input from the chaplaincy can be invaluable. But there are times when for a genuinely holistic approach to be offered, it falls to the doctor, nurse or carer to respond. We know from service user-led research that this is being asked of us<sup>49</sup> and since wholeness and healing are but two sides of the same coin, neither should we find it surprising.

Unfortunately, in the industrialised world we find ourselves up against a social and cultural divide, deeply ingrained, which finds little or no place for healing in from mainstream health care. Yet the surge of interest in complementary and alternative medicine, based on the holistic approach, indicates a change in the climate of our times. People are voting with their feet; in the US, 40% of consumer spending on health goes on complementary treatments and it is growing in the UK too. The Prince of Wales Foundation for Integrated Health is furthering the cause and recently, the Royal College of Psychiatrists set up a joint working party with the Foundation to begin exploring areas of common concern. This could be a timely and productive liaison.

Mental illness always produces fragmentation of the psyche and for any real recovery, healing must be helped to take place. Healing begins with the offering of love, a word that doesn't figure nearly enough in the lexicon of psychiatry. Compassionate love - spirituality in action - can only do good and mixes well with all other treatments that may be required. And who would want to turn down such a precious gift that comes free?

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