

# Spirituality, Healing and the Mind

Dr. Andrew Powell

## Introduction

Healing and wholeness share the same root, of 'Hal', 'Hel, or 'Heil' in Saxon, High German or Old Norse. This reminds us that any discussion about healing has to address the longing for wholeness that has such universal appeal. A central archetype of humankind, it is symbolised by the mandala, the circle that represents completeness, harmony and balance.

Carl Jung, among others, paid great attention to the mandala <sup>1</sup>. Within the circle is often found a quaternio, in which conflicting forces or elements are juxtaposed requiring synthesis, the healing of a dis-unity, and which the circle embraces.

Yet, in western medicine and surgery, the use of the term healing is now generally confined to damage to the skin, such as a wound, burn, or surgical incision. As to more systemic or internal disorders, we speak of recovery rather than healing, not insignificant since the derivation of recovery is from re-cover, or covering over.

There is another term beloved of western medicine that betrays the same shift of focus away from healing. Pathology derives from the Greek, pathos, meaning suffering. Medical science has appropriated the word to stand not for 'dis-ease' as something experienced, but to describe abnormalities of the structure and function of the body. This mechanistic view of the organism has led to great attention being paid to the car, but not the driver.

Psychiatry has trodden the same path and the neurosciences, which give primacy to brain structure and function, have a near-iconic status. When brain lesions like tumours give rise to abnormal mental states, we are at least in step with medicine and surgery in speaking of pathology, in this case neuropathology. But even though most mental illness cannot be explained by physical, chemical, metabolic or hormonal influences, psychiatrists refer to psychopathology, or disease of the mind. This is justified either on the grounds that the physical cause has yet to come to light or, failing that, to indicate the extent to which an individual's thoughts, feelings and behaviour have departed from the consensus norm of society <sup>2</sup>.

## Healing versus Cure

'Diseases' can be treated with specific remedies and in the best cases a cure is obtained. In medicine there are a sufficient number of genuine cures to disguise the fact that most diseases are chronic and cumulative, especially with ageing, and that amelioration of symptoms is often the best that can be hoped for. But 'cure' is a magical word, one which patients are as reluctant as their doctors to dispense with. For cure slays death, or at least promises to stay its hand.

The objectives of cure and healing lie, therefore, on parallel continua:

### Cure

Maximal disorder (symptoms of disease) ----- Minimal disorder (symptom remission)

### Healing

Minimal health (illness) ----- Optimal health (wellness)

(adapted from Swinton <sup>3</sup>)

This raises the paradox that a person may have a terminal disease and yet be well, in the sense of health as wholeness of being. Health reflects the degree of adaptation to the conditions of life. It also is why we can speak of healing into death. To die peacefully and in repose, feeling that one's life was rich in experience and opportunity, that one made the best of it, to have loved and experienced love, and to continue feeling with, in and of the world while yet taking leave of it, is to die healed <sup>4</sup>.

### **Mental Health and Spirituality**

Despite the strong research evidence that spirituality and health are positively correlated <sup>5</sup>, spirituality has been regarded within mainstream medicine as largely irrelevant to the work of the clinical team. In psychiatry, too, this is very much the case, especially since religious and spiritual themes have come to be identified with illness and regarded through the lens of pathology. Patients' attempts to talk about their spiritual beliefs and concerns are met with incomprehension and mistrust. Sometimes the chaplain will be called in but frequently the patient will be advised not to dwell on such matters, or else will find those experiences dismissed as delusions or hallucinations, despite evidence that up to a half of patients count their beliefs as very important in helping them get through a breakdown <sup>6</sup>.

The psychiatrist, frequently beleaguered and trying to maintain an emergency service with pitifully inadequate resources, relies first and foremost on medication, secondly on social support networks, thirdly on psychological interventions where deemed appropriate and least of all, on spiritual sources of strength. On top of that, he/she is three times less likely <sup>7</sup> to hold a religious faith than the patient <sup>7</sup>.

### **The Spiritual Agenda**

Across creeds and cultures, there is the belief that the soul takes a body for the purpose of incarnate existence. This is either a mass delusion, as Sigmund Freud would have us think <sup>8</sup>, or an archetypal awareness of the eternal nature of the soul, which we carry with us into material reality, the world of sense perception <sup>9</sup>.

Different religions variously describe the journey of the soul, its passage through life, its destination, and what is to be experienced there, in various ways. Yet common to all (and just as salient for those who do not belong to a faith tradition) is the belief that life is a profound spiritual challenge. Our emotions, which depend on our physiology as much as our consciousness, take us through a roller coaster of joy and pain, delight and despair. The formation of an integrated personality, served by appropriate ego functioning, is needed to sustain us in this developmental task. Maturity of vision and understanding is hard-won, for we mostly learn through our mistakes. But in raising our level of consciousness we become aware of the greater meaning and purpose of our lives. Suffering without meaning diminishes, but suffering that has meaning is a spur to growth. And in our soul-searching, we always come back to questions like 'Why are we here', why must I suffer, what is it all for, is there more to life than chance – is there anything beyond this birth and death?'

It is remarkable that psychiatry has never entertained this greater picture, since breakdown so often confronts people with deep existential anguish. Clearly problems of living, concerning families, relationships, jobs and the like, all need to be addressed and for this we have a biopsychosocial model of reality. But spirituality has been left out of the equation <sup>10</sup>.

This is to be deplored, since breakdown is characterised by a painful sense of fragmentation, or shattering of the psyche, in which there is a profound loss of meaning

and purpose <sup>11</sup>. If there is to be any chance for breakdown to become breakthrough, healing of the traumatised self is essential.

### **The Nature of Trauma**

All trauma is cumulative. It begins with birth with the disunity that accompanies life, the dis-ease that is inevitable and contingent on the anxieties and frustrations of the embodied psyche. When there is inadequate love and support, the trauma that began with birth is continually being re-activated. With cruelty and abuse, the effects of trauma on the developing personality are catastrophic <sup>12</sup>.

To a lesser or greater extent, of course, every emergent self is wounded along the way. The first line of protection is afforded by the employment of ego-defences, which cut in when the threshold to noxious pain is exceeded <sup>13</sup>. There are many of these, repression, denial, splitting and projection, to name but a few. In the case of repression, the aim is to bury the source of pain, not unlike disposing of nuclear waste down a mineshaft. The same dangers apply - the buried 'material' will sooner or later find its way to the surface, when the impact can be as powerful even fifty years on. Denial enables a person to strip an event of its emotional meaning, a pathological detachment that paralyses the emotional life of that individual. Splitting of the psyche relieves us of the painful tension of holding ambivalent feelings, which is to recognise both the virtues and failing in the other, and no less in ourselves too. It results in idealising the one we have chosen to rescue us (from ourselves), and denigrating the one who is perceived as having failed us. Such idealisations always end in tears. Projection entails discharging a painful complex of emotions into someone or something outside of oneself. Then it no longer feels to belong to the self, but can be attacked, often ferociously, in the other. This is the basis of scapegoating - hence the saying that inside every bully is a victim.

I have outlined just some of these internal mechanisms to indicate that from an early age, we are busy defending our sense of self in an alien and frequently hostile world, a stance some people feel obliged to take for the rest of their lives. Survival has been ensured, but at a cost, since these defences work not by uniting the self, but by putting up barriers against psychic pain; consequently there is a diminution of consciousness, which could otherwise bring insight and healing.

### **Overcoming Trauma**

Every person experiencing a mental breakdown has the sense of the world falling apart. The assumptions on which ordinary life rests can no longer be depended on, and the psychic pain is often so extreme that suicide sometimes seems to be the only escape from unbearable torment.

All good therapy works by offering a safe environment in which the client or patient is helped to become aware of how their defence mechanisms have taken over, and how to begin dismantling them. As this takes place, emotional sensitivity is heightened for the underlying pain has to be faced. This is done with the support and concern of the therapist much as a mother will attend to her child in distress. But three factors often limit the progress. One is that while attention is given to the analysis of defences, not enough is given to the healing itself. The second is that while understanding is offered by the therapist, it falls short of love. The third is that the frame of reference is bounded by psychological reality, and what lies beyond, the spiritual domain, is ruled inadmissible <sup>14</sup>.

### **Love and Need**

Finding wholeness of being is not something we can accomplish alone. The first experience for the human infant comes from being lovingly held in its mother's arms.

With birth has come the disruption of the state of quietude and rest in utero, to be closely followed by a variety of distress, colic, chafing, hunger pains, cold and the like. These impingements threaten the nascent integrity of the infant psyche and are all traumas in the making. But the vibration of love, the encompassing of the child within its mother's aura, the sense of being safely held offers an experience of ontological security that comes to be internalised<sup>15</sup>. The child is now learning to manage tension and distress, not least the pain of loss, without becoming traumatised.

We know from psychoanalysis how in dependency relationships the therapist comes to stand in loco parentis. What is known as a 'transference' develops, the patient bringing into the therapy the unresolved hopes and fears, needs and longings of childhood and unconsciously transferring these feelings onto the therapist.

Understanding these emotions is essential, for what is not made conscious cannot be relinquished. But inevitably these projections entail a distortion of reality - the therapist is not the parent and never can be<sup>16</sup>.

The dynamics of transference are to be found everywhere in medicine, sometimes benign and comforting, but more often disempowering the patient. Indeed, the omnipotence open to the doctor may go beyond that of a parent surrogate to no less than 'playing God'. At the same time, as in all relationships, there is reciprocity of need, for patients look to their doctors for protection from pain, fear of the unknown and, most of all, death. This reciprocal dynamic elicits in the doctor the counter-transference of omnipotence and control.

Yet, the experienced doctor has seen much of human suffering and must respond as best he or she can. The one big obstacle to overcome is the conceit of the human ego. Shored up by our defence mechanisms, unless we are mindful of what we are doing, our egos jump in where angels fear to tread.

### **Love, Spirituality and the Ego**

The good physician is a born healer. The desire to help another in distress is actioned by love, though this is hardly the language of the medical school curriculum. Such love is not ego-driven; there is no self-aggrandisement but an empathic humility that deeply connects the physician with the plight of the patient. In the mental health profession likewise, there is a strong sense of vocation. How otherwise should we cope with the immense stress and lack of palpable rewards?

The basis of empathy is the knowledge that we are like one another, that despite our many differences, we are in essence the same. Consciousness is not a personal possession, as quantum entanglement has demonstrated<sup>17</sup>, for consciousness carries our emotions as the sea carries the wave. When we are open to another, as the mother is to the infant, we re-discover our wholeness of being, for we become as one.

The ego is indispensable to life. Hungry for experience and mastery of the world, it is the locomotive power that takes us forward into the challenges of incarnation. But again, it is not our essence. And ironically, it is the realisation of our mortality, despite the best efforts of our defence mechanisms, which lays bare the limitation of the ego.

Who is this 'I' that can observe the workings of the ego? It is none other than the spiritual core of the human psyche, which has a veridical perception of our brief lives that takes us at once beyond ourselves<sup>18</sup>. For many people, what exactly is meant by spirituality is structured by their religious beliefs. But if we turn to reports of the near-death experience, we find that while the content may be shaped by beliefs and expectations, the essence is the overwhelming experience of being immersed in love so accepting and without judgement that it is possible to know the worst about ourselves and still find forgiveness<sup>19</sup>.

Healing the psyche fortunately does not require such otherworld excursions. But if treatment aims merely to return the patient to the same life circumstances that preceded the illness or breakdown, the result is likely to be further episodes of ill health, since illness, as 'dis-ease', is a profound warning that one's life is seriously out of balance.

### **Soul centred therapy**

All healing is ultimately self-healing, but the right conditions have to be in place. These require exploring with the patient, compassionately and without fear or prejudice, those areas of conflict, inhibition, anxiety and fear that deeply affect a person's well being.

Every humanitarian good deed is driven by the spiritual impulse, whether consciously acknowledged or not. Much psychiatry goes on at this level, but it is none the less a serious failing that the mental health professions are not taught how to take a spiritual history just as they are taught to take medical and social histories. For example

<sup>20</sup>.

- Does the patient use religion or spirituality to cope with illness, or is it a source of stress?
- Is the patient a member of a supportive spiritual community?
- Does the patient have any troubling spiritual questions or concerns?
- Does the patient have any spiritual beliefs that might influence medical care?

These simple enquiries quickly open the way to deeper discussion if desired, with a number of important consequences:

1. The reductive/analytic questioning needed to pinpoint the source of the problem is nested within a unitive spiritual perspective.
2. It can be readily ascertained whether a person believes that there is a greater (transcendental) reality. If so, issues of separation and loss, disability and suffering take on a new meaning.
3. The door may be open to working transpersonally, using approaches in line with the patient's own beliefs.

For instance, in the Judaic, Christian and Islam faiths, the power of prayer may be harnessed <sup>21</sup>. Meditation, drawn from the Buddhist tradition, can form a valued part of therapy <sup>22</sup>. Belief in reincarnation, these days held widely in the West, as well as by the Hindu faith, allows for an exploration of karma, and the possibility of healing through 'past life' therapy <sup>23</sup>. If a person feels the presence of unwelcome spirit attachment, spirit release therapy may prove to be an effective intervention <sup>24</sup>. Other times it may be appropriate to work in the shamanic tradition with soul loss and recovery <sup>25</sup>.

How any one therapist responds to the psycho-spiritual dimension of a mental health problem depends on training, skills and, most importantly, the willingness to be engaged. Without this, no therapy will get off the starting blocks. Given the tradition and culture of mental healthcare in the United Kingdom, some basic steps need to be taken. Spiritual history taking is essential and should be routine. Religious or spiritual prejudice in the therapist, which may not be immediately apparent, must be addressed in the same way that problems of transference and countertransference need to be identified in all good clinical practice <sup>26</sup>.

When the therapist acknowledges the authenticity of the truth a patient holds most precious, there is a deep contact that can sustain the patient caught in a nightmare

reality<sup>27, 28</sup>. Nor need the therapist be afraid of the love that is evoked, for this is the source of healing. When the heart is open, there is the realisation that this love is as dispassionate as compassionate - that it is not contingent on the personalities of patient and therapist but arises from a source beyond, and greater than, the ego. Sometimes this is named, but it need not be for the Divine is present in the smallest acts of mercy.

A holistic therapy is one that addresses the needs of the whole person. But holism also asserts that the whole is greater than the sum of its parts. As Jung said, '...for analysis is always followed by synthesis, and what was divided on a lower level will reappear, united, on a higher one'.<sup>29</sup>

No matter how fractured the psyche, there is always a longing to find wholeness, and ultimately only this wholeness of being can lovingly embrace and forgive the trauma. Sometimes our patients mistakenly seek death as the means to that end. Our task as doctors and therapists is to help them to discover that such healing does not have to wait on death; it is the essence of life.

## References

1. Jung C. (1916) 'The Transcendent Function', in 'The Structure and Dynamics of the Psyche', *Collected Works*, Vol. 8. London: Routledge and Kegan Paul, 1960
2. Powell A. (2003) 'Psychiatry and Spirituality – the Forgotten Dimension' [www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm](http://www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm)
3. Swinton J (2001) *Spirituality and Mental Health Care* London and Philadelphia: Jessica Kingsley Publishers
4. Kearney M. (1996) *Mortally Wounded* Dublin: Marino Books
5. Koenig HK, McCullough ME, Larson DB, (2001) *Handbook of Religion and Health* Oxford: Oxford University Press
6. Faulkner A. (1997) *Knowing Our Own Minds*. London: Mental Health Foundation
7. Shafranske EP. (2000) 'Religious involvement and professional practices of psychiatrists and other mental health professionals'. *Psychiat. Ann.* 30 (8): 525 – 532
8. Freud S. (1927) 'The Future of an Illusion' Reprinted (1953 – 1974) in *The Standard Edition of the Complete Works of Sigmund Freud* (ed. and trans. J. Strachey) Vol. 21. London: Hogarth Press
9. Powell A. (1998). 'Soul Consciousness and Human Suffering' *Journal of Alternative and Complementary Medicine* 4 (1): 101-108
10. Powell A. (2002) 'Putting the Soul into Psychiatry' [www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm](http://www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm)
11. Ulman R, Brothers D. (1988) *The Shattered Self* Hove and London: The Analytic Press
12. Kalsched D. (1996) *The Inner World of Trauma* London: Routledge
13. Powell A. (2002) 'Psychosocial Implications of the Shadow' [www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm](http://www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm)
14. Powell A (2003) 'Consciousness that transcends spacetime – its implication for the therapeutic process' [www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm](http://www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm) and *Self and Society* Vol. 31:4 2003
15. Powell A (2003) 'Love and the Near Life Experience' [www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm](http://www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm)

16. Powell A. (1994) 'Ending is for Life' *Group Analysis* 27 (1): 25-36
17. Powell A. (2001) 'Beyond Space and Time – the Unbounded Psyche' in *Thinking Beyond the Brain* Ed. Lorimer D. Edinburgh: Floris Books
18. Powell A. (2001) 'The Unquiet Self and the Search for Peace' *Sacred Space* Vol.3. (4) 6-13 and [www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm](http://www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm)
19. Bailey LW, Yates J. (1996) *The Near Death Experience* New York and London: Routledge
20. Koenig HK. (2002) *Spirituality in Patient Care* Philadelphia and London: Templeton Foundation Press
21. Perry J. (2000) *A Time to Heal: a Report for the House of Bishops on the Healing Ministry* London: Church House Publishing
22. Kabat-Zinn J. (1990) *Full Catastrophe Living* New York: Delacorte
23. Woolger R. (1999) *Other Lives, Other Selves*. New York and London: Bantam Books
24. Powell A. (2001) 'Inspiration and Persecution: Messages from Self and Beyond' *Network – The Scientific and Medical Network Review* 77: 17 - 21 December 2001 and *Nexus* Vol. 9:3 2002 as 'Quantum Psychiatry: where science meets spirit'.
25. Rutherford L. (1996) *Shamanism* London: Thorsons HarperCollins:
26. Larson DB, Larson SS. (2001) 'The Patient's Spiritual/Religious Dimension: A Forgotten Factor in Mental Health' *Directions In Psychiatry* Vol. 21 Lesson 21 and [www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm](http://www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm)
27. Powell A. (2001) 'Spirituality and science: a personal view' *Advances in Psychiatric Treatment* 7: 319-321 and [www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm](http://www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm)
28. Powell A. (2002) 'Mental Health and Spirituality' [www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm](http://www.rcpsych.ac.uk/college/sig/spirit/publications/index.htm)
29. Jung C. (1942) 'Paracelsus as a Spiritual Phenomenon' in 'Alchemical Studies', *Collected Works* Vol. 13 p.189 London: Routledge and Kegan Paul 1968