

Report of Spirituality SIG talks given by invitation to the Faculty of General and Community Psychiatry Annual Residential Conference 'Evolving Services, Evolving Treatments', Cardiff, 15/16th October 2009

The SIG was delighted to be asked to contribute to this meeting, and three speakers, Professor Chris Cook (Chair), Dr. Larry Culliford and Dr. Simon Dein offered to contribute with talks on Addiction and Spirituality, Assessing Spirituality and Schizophrenia and Religion respectively. All three presentations prompted lively discussion and the speakers felt encouraged by the awareness in general psychiatry of the need to recognise issues of spirituality in daily clinical work.

Professor Chris Cook: 'Addiction and Spirituality'

Spirituality has been emphasised as an important factor in recovery from addiction for many years, although not always explicitly. Spirituality is seen as important not only by the world's major faith traditions but also, in a secular form, by Alcoholics Anonymous and other 'Twelve Step' programmes. Now it is also becoming an important variable in addictions research.

Spirituality is variously defined and measured. The empirical research literature on addiction and spirituality is still relatively small and rather heterogeneous, but applications of spiritual principles in recovery are widespread – especially in Twelve Step programmes. Research is also beginning to show evidence of an impact on outcomes. This is therefore something which should not be neglected in NHS treatment programmes.

Addictive disorders present spiritual, as well as bio-psycho-social, issues which need to be addressed in treatment. These include relational issues (e.g. the need to give and receive forgiveness), as well as the seeking of a transcendent source of help (e.g. the 'Higher Power' of Twelve Step programmes), the importance of daily spiritual practices and the benefit derived from extending help to others who suffer. It is possible to address these considerations in NHS treatment facilities in such a way as to be open to those whose spirituality is associated with any of the world's major faith traditions, or the Twelve Step movement, as well as those whose spirituality is more individual and not associated with any particular faith or other tradition.

Dr. Larry Culliford: 'Assessing Spirituality'

This paper, based on an earlier article in *Advances in Psychiatric Treatment* (Culliford 2007) and the chapter 'Assessing Spiritual Needs' (Culliford and Egger 2009) in *Spirituality and Psychiatry* (Cook, Powell and Sims 2009) addressed the topic according to four main headings: Why? How? Who? and What next? The following points were highlighted:

- Spirituality can be considered supra-ordinate to, and an integrating force for, the other dimensions of human existence: physical, biological, psychological and social
- It is not necessarily about religious beliefs and practices
- It is, however, about wholeness, universality and a principle of reciprocity, about developing a feeling of self-worth, finding meaning, having a sense of purpose and of belonging
- Spiritual crises can mimic and/or co-exist with mental illnesses
- Two main types of question get quickly to the heart of a person's spirituality: 'Do you consider yourself religious or spiritual in any way?' (with encouragement to explain) and 'What helps most when (perhaps due to your illness) life gets really difficult?' - where do you look for inner strength, courage and hope? Where, or to whom, do you turn for emotional and/or practical support?
- Structured approaches to spiritual history-taking that are available include those with the mnemonics of SPIRIT, FICA, HOPE, and FAITH
- Spiritual practices can be both religious and secular in nature; for example, reading scripture and reading secular literature, poetry and philosophy
- All types of mental healthcare professional have been enjoined by their professional bodies to take account of patients' spirituality and be capable of some form of spiritual needs screening
- Referring on for more detailed assessment and care to chaplains or clinicians with a special interest and experience should follow in some cases
- Spiritual issues may be particularly important in patients when poor motivation, low self-esteem and loss of meaning are involved, perhaps especially (noting the success of twelve-step treatment methods) in cases of addiction
- The 'holistic' or 'bio-psycho-socio-spiritual' approach is therefore advised in all mental health assessments for reasons that include the deepening of rapport that often results between patient and clinician

References:

- Culliford, L. (2007) 'Taking a Spiritual History' *Advances in Psychiatric Treatment* 13: 212-219
- Culliford, L. & Egger, S. (2009) Chapter: 'Assessing Spiritual Needs', in Cook, C., Powell, A. & Sims, A. (Editors) *Spirituality and Psychiatry*. London, RCPsych Publications

Dr. Simon Dein: 'Schizophrenia and Religion'

Historically, religion and madness have been held to be closely related. Extreme religious behaviour is often labelled as madness. There has been a long-term debate on the mental health of the shaman among social anthropologists, some of whom have even argued that all religious cognition is psychotic (e.g. La Barre 1970). There are a number of empirical associations between religion and schizophrenia. Patients suffering with schizophrenia demonstrate high prevalences of religious delusions. In a recent UK study, 28% of in patients with schizophrenia reported religious delusions (Siddle, 2002). Religious and paranormal preoccupations are common in those individuals with schizotypy. The phenomenological features of both schizophrenia and various religious experiences demonstrate considerable overlap. Pentecostal Christians experience God's voice coming from outside their heads and some experience God's thoughts entering their minds. Finally, members of New Religious Movements such as the Hare Krishna score highly on delusional scales. To what extent is this association intrinsic?

Individuals with schizophrenia frequently resort to religious forms of coping including the use of prayer, the support of the religious community and reading liturgy. Religious coping may alleviate some of the distressing symptoms of schizophrenia such as hallucinations and there is some evidence that higher religiosity may improve the prognosis of those suffering with schizophrenia (Mohr, 2006).

We (Dein and Littlewood) propose that schizophrenia and religious cognition employ the same mental modules: agency detection and theory of mind. There are similarities and differences between assumptions of ultra-human agents with omniscient minds and certain 'pathological' forms of thinking in schizophrenia: thought insertion, withdrawal and broadcasting, and delusions of reference. In everyday religious cognition, agency detection and theory of mind modules function 'normally', whereas in schizophrenia both modules are impaired. Religion and schizophrenia may have similar evolutionary origins. In both religious experience and schizophrenia there is a breakdown of boundaries between the self and the outside world.

References:

- Dein, S., Littlewood, R. Transcultural Psychiatry (accepted for publication)
La Barre, W. (1970) *The Ghost Dance*. London: Allen and Unwin
Mohr, S., Brandt, P., Borat, L., et al. (2006). 'Towards the integration of spirituality and religiousness into the psychosocial dimension of schizophrenia'. *American Journal of Psychiatry* 163:1952-1959.
Siddle, R., Haddock, G., Tarrier, N. et al. (2002). 'Religious delusions in patients admitted to hospital with schizophrenia'. *Social Psychiatry and Psychiatric Epidemiology* 37:130-8.