THE ROYAL COLLEGE OF PSYCHIATRISTS

SPIRITUALITY AND PSYCHIATRY SPECIAL INTEREST GROUP

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Dear Member,

Welcome to the first of our Newsletters intended primarily for the Spirituality and Psychiatry Special Interest Group Website. Browse through this issue (and the past issues, which are being stored in the archive) and download at your leisure.

Our thanks to Lynn Reynolds at the College for enabling us to take this step and to Dr. Maya Spencer, who will be overseeing the site.

Special Interest Groups are now in the public domain, so we hope that all interested persons will be able to enjoy and make use of the articles, the spirituality database and links that will be available through the site. **Members who have papers or articles of interest they would like to have published on the Website should send these as Word files to me at sduncan@rcpsych.ac.uk.** Publication is at the discretion of the chair and steering group. Please ensure that there is no conflict with any existing copyright.

Much has been said, and written, about the tragic events of September 11th and there was never a greater need for a global spiritual perspective. A common theme of the contributions to this newsletter is the recognition that without a sense of wholeness of being, love cannot flow. For the sake of our world, may we find unity in diversity!

Dr. Andrew Powell, chair.

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'THE HEALING POWER OF LOVE'

Research Findings on Patients' and Nurses' Perceptions and Views on Spiritual Care in Mental Health Practice
and
Overcoming Barriers to the Provision of Spiritual Care: the place of compassion in clinical practice.

Mary Nathan MSc.

Reported by Dr. Gillian Broster

Mary Nathan trained in general nursing, midwifery and in mental health. She has nursed in Nigeria and served as a General Nursing Council examiner. Currently she holds the post of Research and Practice Development Nurse in the Ealing, Hammersmith and Fulham Mental Health Trust. The study described here forms part of what is to be a larger multi-centred study. Mary has a deep concern with spiritual care in mental health practice.

Mary began by explaining that the study had two objectives. The first was to explore patients' and nurses' perceptions and views on spiritual care. The second was to elicit whether or not mental health nurses feel sufficiently competent to assess and provide spiritual care to their clients. This was a descriptive study, which took place on an acute mental health unit. Eighty-eight qualified mental health nurses participated, coming from a range of ethnic origins, including Afro-Caribbean, Black African, Caucasian, Asian and others. Their religious backgrounds were diverse.

The nurses were asked a wide range of questions. They were also asked if they had any training or qualification in spiritual care.

Data Analysis was by SPSS, the Statistical Package for Social Sciences. Findings from the nurses' questionnaires showed that:

- There was a lack of clarity with the concept of spirituality.
- Spiritual care was strictly defined as meeting the patients' religious needs.
- Spirituality is not clearly featured in the curriculum or taught during, or after, training.
- There was no clear view as to who should be held responsible for this area of care.
- Additional comments were made that training should be provided and that there should be a working definition and guidelines for practice.

Nurses were asked to give their own definitions of what was meant by spiritual care. The following are some examples of answers given:

- Attending to patients' religious needs.
- Form of care directed exclusively towards the soul and its function as a link between the mind and body.
- The care that promotes a sense of belonging and offers alternative coping skills.
- The care that provides peace, hope and faith in God.
- Helping patients to identify their own spiritual needs.
- The care that is concerned with the esteem needs of the individual.
- Provision of meaning and hope to lean on, to help with moving on.
- Allowing patients to talk about death and dying.
- Looking after the thing that keeps a person going.
- The provision of that which, in addition to the necessities of life, provides a framework for the person's life.

The majority of nurses thought that spiritual care was to do with religion in some way.

In the patient sample, which numbered thirteen, 54% were male and 46% female. They came from a range of religious backgrounds. Diagnoses included paranoid schizophrenia, bi-polar disorder, alcohol dependence and schizoaffective disorder. Some had attempted suicide. The duration of illness was from 1 year to 25 years and the age range was from 20 – 55 years.

Examples of questions that were asked were:

- What does spiritual care mean to you?
- Should it be provided in the hospital?
- During a stay in hospital were you provided with some form of spiritual care?
- Would you have benefited if it had been offered?
- Who should provide spiritual care?
- Do you think spiritual care is as important as other forms of care?

As with the nurses, all patients equated spiritual care in some way with religion. Here, the emphasis seemed to be on harmonious communication - the patients wanted help to understand their illness. Mary gave examples of patients' definitions of spiritual care:

- Spiritual care is talking with patients about God.
- Spiritual care is in loving your neighbour as yourself.
- Spiritual care is assisting those who are weak and need help.
- Spiritual care is 'like the Good Samaritan stuff'.
- A longer definition given was, 'Spiritual care is when you are weak someone gives you strength, when dirty someone cleans you up, when hungry someone gives you food, when thirsty someone gives you drink, when confused someone stays by your side, when wanting to end your life someone gives you hope, when frightened someone calms your fear, when no-one cares about you someone holds your hand and gives you a smile."

Mary then discussed the story of the Good Samaritan (Luke 10: 30-37). The priest did not stop, neither did the Levite, but it was the Samaritan, who was of a lower class, a person looked down upon, who actually helped. In the parable, it was the one who belonged to no particular religious group who was the person to do everything for the man who had been attacked and had fallen by the wayside. This was what patients meant by spiritual care.

Mary went on to say that the main source of the world's ills was lack of love. There are two basic qualities, which define us as human beings, sharpness of mind and kindness of the heart. She mentioned Mother Teresa in this respect who has said that the biggest disease of today is not TB or leprosy but a lack of being cared for and loved.

Mary contrasted the patients' definition of spiritual care with that of the nurses'. Nurses related spiritual care to religious care, whereas patients related spiritual care more to qualities of life and recovery. Points highlighted were helping patients find meaning in their experiences by listening to them when they express their concerns, and supporting them to talk through their problems. Patients wanted to feel accepted, that they belonged and were safe, were valued and loved. Practitioners should treat patients with the respect and dignity as individuals and fellow human beings that they themselves would like to be shown. What is important is recognising and respecting patients' values and religious beliefs and providing the necessary resources for these needs.

Both patients and nurses had made additional comments. Patients thought it was important to dispel the myth that any forceful religious expression is a sign of madness and emphasised that everyone needs spiritual care. They wanted the opportunities and resources to express feelings appropriately and to make contribution to the society through structured work or leisure. More staff and activities were needed.

Nurses commented that training in spiritual care should be arranged as part of continuing education and that spiritual care should be included in the care plan of patients. However, they thought that spiritual care should be provided by the priest. Some were unsure of what spiritual care was and even thought spiritual care could increase patients' delusions. Another comment made was that 'this is an acute admission ward, not a church' and that if clients needed spiritual care they could request to see the priest of their faith.

In summary, Mary pointed out that patients' perceptions of spiritual care differed significantly from that of the nurses. While the patients associated spiritual care with religion, all the patients regarded spiritual care as more encompassing than mere religious practice. Patients described spiritual care holistically and related it strongly to their quality of life and recovery. By contrast, nurses described spiritual care as referring to the religious needs of the patients and were unclear who should be responsible. Nurses demonstrated a lack of confidence and expertise regarding spiritual care but did express an interest in undertaking training when provided.

Research implications were that this study needed replicating in other mental health care settings. There was the question of whether specialist practitioners in spiritual care should be trained and if so, how to commence training and how to provide prophylactic and therapeutic spiritual care.

Discussion: It was thought important to tease out what is meant by spirituality and what is meant by religion. It was pointed out that the General Medical Council states that it is appropriate for doctors to share their religious beliefs with patients *so long as it does not put pressure on the patient*. One way of looking at spirituality is that it is not encapsulated but underpins all we do. Care and compassion should be at the basis of all our work. Did we need to define spirituality if we are going to be able to investigate it? The chair reminded the meeting that in setting up the Spirituality in Psychiatry Group, it had been decided that spirituality should not be tightly defined. Some people believe that 'spirit' is primary and we are spiritual beings in physical bodies (hence survival after physical death) while others hold that spirituality carries no such implication. Mary warned against being so restrictive in our definition of spirituality that we become like the priest or Levi in the Good Samaritan and pass by on the other side of the road! The discussion closed with the comment from the chair that both perspectives were important. Sometimes the big existential questions of life and death have to be faced. Other times the need was simply for compassionate care, when a person might be feeling lost and alone.

Possible Barriers to the Provision of Spiritual Care

Mary put forward the following list of possible barriers for discussion.

- Inadequate educational preparation and lack of competence in spiritual care.
- Emphasis may be placed only on biopsychosocial issues
- Spiritual care has been described as lacking a scientific base, compounded by the associated problems of time constraints and shortage of human resources
- Lack of clarity of the concept.
- Religion is taken to be synonymous with spirituality.
- There are conflicts in belief and value systems among mental health professionals,
- Spiritual care can be personally challenging to most mental health practitioners and the practice setting or institution may be a barrier.
- There is an absence of the right kind of relationship between the clients and the practitioners (it has been described as the 'it and thou mentality'), reflecting a rigid model of care.

As to overcoming possible barriers to spiritual care, Mary proposed the following:

- Promoting and utilising educational opportunities in spiritual care and empathising with the whole person.
- Recognising the limitations of science and prioritising limited resources.
- Working at what is known until the unknown is clarified.
- Recognising that religion and spirituality are not synonymous.
- Addressing the challenges spiritual care poses to health care practitioners and practising a holistic approach to care.
- Using positive attitudes towards self and others and implementing care interventions that address the whole person.

Mary described a 'compassion scale' that she has devised for her research. (This stimulated the group to think about the actions we take as psychiatrists and whether they are to alleviate pain or because it helps us feel better. Whose sense of safety and well being comes first? There is a need for honesty. Do our actions promote the quality of life for our patients or do they afford us a position of power and control over that person? We could try asking the question 'would I be happy to be treated in that way'?)

Mary then looked further at the question 'What is spiritual care? *It can be seen as providing the necessary resources to address and support people's values and beliefs, provided these values and beliefs place no individuals at risk.* It is based on treating each person with respect and dignity, promoting love, hope, faith, and helping vulnerable people to find the strength to cope at times of life crises when overcome by despair, grief and confusion.

Discussion: What implicit attitudes are held by mental health professionals? Are psychiatrists more sceptical of spirituality than the population at large? Service users say how much their spiritual beliefs have helped them cope with illness but feel unable to discuss it with the psychiatrist. Yet if Jung's concept of the wounded healer is to be taken into account, the mental health professional is well qualified to support an attitude of spiritual enquiry when the patient shows signs of wanting to explore spiritual concerns.

Mary then proposed the following key aspects of spiritual care:

- Acceptance: accepting people as they are.
- Help: helping people to be what they can be.
- Affirming: affirming people when they feel weak
- Giving: giving strength to set people free.

The point was raised that people enter the vocational professions, including medicine, social work and teaching, because they are spiritual beings but seem to have the spirituality knocked out of them during training! It seems that neither the training, nor the

work environment, are supportive of the spiritual task. As to psychiatry, the idea was mooted of establishing local networks, to find ways to prevent burnout and disillusionment. Mary, in summing up, made the point that in the final analysis, it is deeds not words that count, as Illustrated so powerfully in the parable of the Good Samaritan.

In the afternoon of the meeting on 8th November, Dr. Larry Culliford and Dr. Sarah Eagger presented papers; their texts are reproduced here by kind permission of the authors.

Psychiatry – A Labour of Love? (A Journey in Search of No-Self)

By Dr. Larry Culliford

Introduction:

Given the title, there is no way to avoid this being a substantially personal view. I hope you will not think it too self-indulgent. Be that as it may, I should like to begin with a passage from the recent College Newsletter by someone else – the College registrar (Shooter, 2001). He writes:

> *'Given the current opprobrium heaped on psychiatrists… I must really love this job – because only a fool would do it otherwise.'*

These sentiments echo those of an article in The Guardian in 1984, which was called, 'Are Psychiatrists Nuts?' in which the author describes his work and alludes to its benefits. I will say more about this later, but in the meantime, here is a true story. It is about love – and I find that I want today to explore the subject of love, especially the spiritual dimension of love, more than that of psychiatry, although I do of course want to tie them together.

True Story (from Whiteside (2001)).

A man, Danny, fell in love with a woman. The woman, Elizabeth, fell in love with the man. This happened quickly, and there was soon a significant degree of trust and affection between them.

Elizabeth lived alone in a house and Danny often visited her there. After a time, for the sake of convenience, she had an extra key made for his use. Their relationship flourished. In time Danny proposed, and they were married. After Elizabeth moved in with Danny, she took back the newly redundant key to her former property and had it gold-plated, returning it to Danny as a symbol of their love. Elizabeth wrote a message for him in the card she gave him with the key: "There will never be any locks or barriers between us for evermore". Quite soon after this, however, she developed a serious illness, a cancer, for which surgical treatment was not completely successful. Three years later the disease had spread. Calmly and with courage, Elizabeth eventually died.

Danny was, of course, stricken with grief. The delay between diagnosis of the tumour and Lizzy's death had given him some opportunity to prepare himself, but the blow was a bitter one nevertheless. Little by little, though, he began to recover and to remember more of the happy times they had shared. One night five or six years after she had died, Danny had a peculiar dream. By coincidence a friend was staying with him at the time. This friend, John, was an experienced psychotherapist, and was used to helping people interpret their dreams. As they sat at breakfast, Danny tried to describe his experience during the night.

He recalled walking in the dream down a narrow street after dark. To his right there was a building behind a wall. It seemed like a large private house, but he did not feel particularly interested in it because he was intent on continuing down the road. Several people seemed to be waiting for him there, although he did not know who they were. As he

passed by, he was just aware of a single light in the upper window of the darkened house, and it occurred to him that there might be a woman there. He thought perhaps he had a glimpse of her shadow passing quickly across the window, but when he looked up he could see nothing.

In the dream, Danny's attention now turned to the downhill curve of the lane and to the people waiting for him, but as he was leaving the house behind he noticed an upended brick on the path beside the wall. On top of the brick, he suddenly saw, was a key. In the dream, and as he spoke of it to John, he thought little of it, but John stopped him and asked about it. "Keys are often significant in dreams", he said. "Can you think about it some more? Could it somehow be connected to the shadowy woman?"

In a flash Danny remembered Elizabeth, and the gold-plated key she had given him. He even went to fetch the still shiny, precious golden object from its safe place in another room to show his friend. He remembered again Elizabeth's message, "There will never be any locks or barriers between us for evermore", and he remembered the innocence, the purity with which he had loved her, the joy and contentment, the mutuality, the total acceptance of each other between the two people.

It was a wonderful and powerful feeling, different from anything Danny had known before, even at the height of his love for Elizabeth. All the components of happiness were present and none of the painful emotions, but this time the feelings were not just connected to his wife. Somehow Danny knew that this loving sense of irrevocable inter-connectedness was present between all human beings, including all those that had died and gone before, and those not yet born who would come after.

Danny knew instantly – and unequivocally – that there are ultimately no barriers between people, except for those that we erect ourselves. He knew then that at the deepest level we are unified and interdependent, and that the nature of this unity is love. This was the true meaning of Elizabeth's gift. Much greater than a personal love between the two, it had now metamorphosed into a universal and enduring one between himself, herself and all people of all time. Utterly transformative, this momentous insight was to change his life for the better forever.

(If you want to know how Danny reacted to this experience – an experience of healing and growth – you will have to get hold of a copy of my book.)

This story sets the scene for us on the subject of psychiatry as a labour of love. Stuart Johnson, co-author with me of 'Healing from Within' (Johnson & Culliford, 2001), recently told me about a 72 year old man in a psychiatric hospital saying, *'I feel God's love deep inside of me – and it's what keeps me going'*. Stuart said that the man also felt the love of the church, and that that too made an enormous difference to him.

As well as *divine* love, this man feels support from an institution that he perceives as caring. To what extent do our patients experience the institutions of medicine and psychiatry as similarly loving and compassionate? We can discuss this point later.

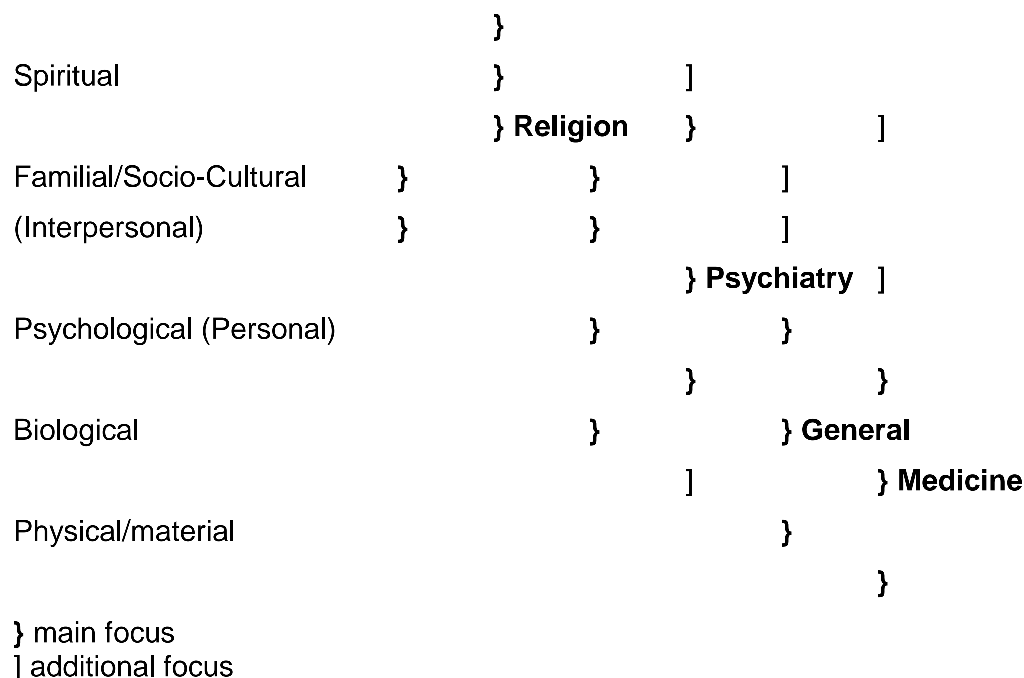
Like Stuart, I also frequently ask my patients with long-term problems, 'what sustains you? What keeps you going?' One, a woman in her early forties, estranged from her family because of repeated, severe and prolonged bipolar episodes, recently gave me her answer: 'It is the love of my husband and daughter. Even though I don't see them, hardly ever, I always remember how they loved me.' She also had a belief in what she referred to simply as, 'something greater', which sustains her. She wears a crucifix and other charms, which symbolise particularly her reciprocal love for her daughter, and clearly gains a kind of spiritual comfort from this.

Let us try and look a little closer at what this love really is.

Dimensions of love

I have found that in order to do full justice to something, we must examine all its different dimensions.

Figure1: Dimensions of Human Experience



Starting at the bottom of this hierarchy, love's physical dimension – presumably to do with the endorphins and such like – does not concern us much here today. Neither really does the biological dimension, its neuro-humoral basis and so on. I am not even going to say much about sexuality, important though it undoubtedly is, except to note that it too has biological, personal, inter-personal and socio-cultural dimensions, separable but also somehow intimately integrated.

Already we have spoken of love between individuals, love in the context of institutions, the universality of love between people, and of God's love. These belong to the top three dimensions, but also hint powerfully at *seamless* interactions and inter-connections between them.

This, I think, is the point of love – it is dynamic. It both flows and unites. It forms the living matrix of creation.

Mature and immature love

But there is an important distinction to be made, I think, between mature and immature love. I mention this here as a prelude to talking about personal growth. I have listed some of the distinctions in the following diagram.

Immature Love	**Mature Love**
Selfish	Selfless, compassionate

Possessive	Free
Indifferent at times	Always caring
Partisan	Altruistic
Passion (preponderance of painful emotions)	Equanimity (preponderance of pain-free emotions)

Love and psychiatry

The quote from the College Registrar indicates a truism, that love is not defeated by opposition, but strengthened. I have written in 'Happiness – The 30-Day Guide' (*Patrick Whiteside* is the author's pen-name), about a possible mechanism for this involving a new checklist of emotions, both painful and pleasurable, (that some here will have heard me speak of before), all of which are called into play by the inevitable experiences of threat and loss following any attachment.

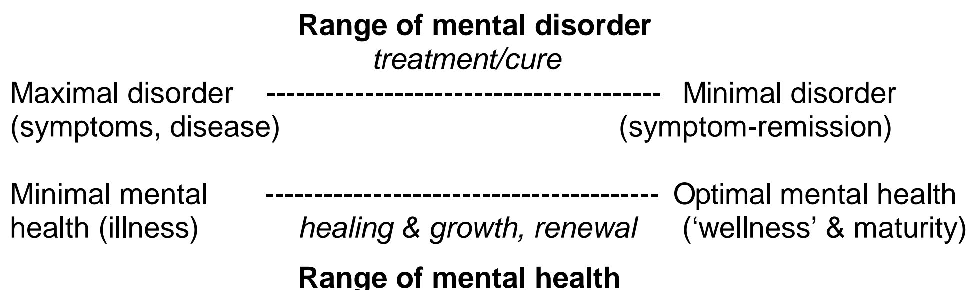
Painful emotions	**Pain-free emotions**
Wanting	Contentment
Anxiety	Calm
Bewilderment	Clarity
Doubt	Certainty
Anger	Acceptance
Shame	Worthiness
Guilt	Purity
Sadness	Joy

To simplify this process – one of healing – sadness heralds the acceptance of a loss and with resolution come not only better feelings, but also personal growth in terms of improved equanimity and emotional resilience, improved creativity and spontaneity, a greater capacity for wisdom, discernment, joy, calm, tolerance, humility, compassion, kindness, generosity – and love. We can call these *spiritual* benefits.

There is a point here about healing and personal growth going together. Cure does not necessarily involve growth. This is one of the distinctions between *'cure',* an aspect of the medical model, and the more holistic *'healing'*. The paradigms of cure and healing can be placed on adjacent continua as shown below.

Figure 2. Health within illness – Trent's two continua.

(adapted from Swinton, 2001 and reproduced in Culliford, 2002)



To quote from the WHO definition of health, ***'Health' is more than the absence of disease.***

Giving up attachment to the ego-self

The most intense and tenacious attachment of all is to the self, more specifically to a person's psychological representation of him/herself, which we may call the ego-self, comprising all that with which (and with whom) one identifies, consciously or otherwise.

The greatest potential for emotional pain and psychological injury therefore arises when this attachment is threatened – but equally, the greatest potential for growth is there too, through the judicious and necessary weakening of this attachment. And we can train for this. We can learn and continually improve our spiritual skills, for example through meditation, yoga and other forms of spiritual practice (perhaps including regular devotion and worship), and not least by doing 'good works'.

This partly explains a central principle of what may be called 'spiritual' care (see Swinton, *2001*), that *offering it benefits both giver and receiver.*

We cannot function as psychiatrists without having to let go, little by little, of the burden of our attachment to the ego-self, and without working towards the kind of universality Danny achieved through his gift from Elizabeth, that golden key. When Stuart Johnson told me of his 72 year old who felt the love of God and of the Church, he added about himself, *'It is so wonderful to be trusted with that kind of information. You actually get so much back from that kind of interaction'.*

And this, I think, is possibly why people like our College registrar love their difficult jobs. There is nothing foolish about it. Why have each of you entered medicine and chosen psychiatry? I look forward to hearing you discussing this point in a minute.

I must now confess that it was I who wrote the article in The Guardian in 1984. Towards the end it reads as follows: *'To the question, "Don't you find the work depressing?" the answer is "No…." We (psychiatrists) are by and large tough people, tough in the sense of resilient. The work makes us so, and perhaps that is why we are attracted to it.'*

'Every day in others I see anxiety, anger, bewilderment, guilt, shame, doubt and sorrow – often in painful intensity. Often, I feel these emotions myself. But equally, every day, I also witness tranquillity, acceptance, understanding, forgiveness, self-esteem, self-confidence, self-control and joy in those around me.'

Perhaps I was a bit naïve 18 years ago, but I hope you will at least partly agree with my observations. My closing words were: *'every day I see people growing – patients, colleagues and all. This is my life. I am alive…and I love my work.'* This is true for me, even today.

In the practice of psychiatry, both individually and collectively, we are engaged in very challenging work. Setbacks occur frequently, if only because, according to Swinton, *'The reality for a significant number of people is that certain forms of mental illness are interminable',* also of course resistant to treatment. Therefore, he says, the aims and objectives of health care professionals are: *'To enable a person to find enough meaning in their present struggles to sustain them, even in the midst of the most unimaginable storms.'* Thus it has to be a labour of love. And I would say that there is a duty we ourselves have – to achieve resilience, emotional stability and spiritually mature ways of living and coping. It is a duty but as we make progress, it is also a joy and a blessing. We grow thankful that the work does demand this of us, and gives us life.

Conclusion

To finish, and explain that comment, I would like to quote one of my favourite spiritual guides, the Trappist monk Thomas Merton, who died in 1968, from his book, 'Love and Living'. Merton is asking, "What is love about? How do you think about love?" He says:

> *'Love is the revelation of our deepest personal meaning, value and identity – but this revelation remains impossible, as long as we are the prisoner of our own egoism.*
> *Love is the transforming power of almost mystical intensity, which endows the lovers with qualities and capacities they never dreamed they could possess.*
> *Where do these qualities come from? From the enhancement of life itself – deepened, intensified, elevated, strengthened and spiritualised by love.*
> *Love is only a special way of being alive. It is the perfection of life. He (or she) who loves is more alive and more real than he was when he did not love.'* (Merton, 1985)

For me, psychiatry has been and continues to be a labour permeated by this kind of love. It gives my life much of its meaning and purpose. I feel somehow genuinely chosen to be a psychiatrist, rather than that I chose the profession.

I should like to add that part of our task is undoubtedly to value, care about and support each other and I am pleased to say I feel especially supported within the College and by this group. Our task is also to try and educate – to draw out – those who wish to follow. It has been a privilege to speak to you today. Thank you for coming along and for giving me your attention.

Acknowledgement: *Extract from HAPPINESS – THE 30-DAY GUIDE by Patrick Whiteside used by permission of The Random House Group Limited*

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Discussion on 'Psychiatry – a Labour of Love?' Reported by **Dr. Daphne Wallace**

The discussion explored the potential rewards of working in psychiatry, and the difficulties that can arise. One participant drew attention to the difficulty of the Christian concept of 'sin' (implying badness). It was suggested that the right word is 'wound'. We are all wounded people. Psychiatry can transform the wound to love. Other members connected this to the concept of 'the wounded healer'. The current challenge is to be able to step back from the pressures and statutory regulations in order to see love.

The source of the pressure was felt to be partly down to sheer numbers, but also due to societal dynamics. There has to be someone found to blame. There is much anger and anguish but due to the pressure we cannot let go and grieve. Society promotes instant solutions and many social problems come to the psychiatrist who may feel powerless, or else feels driven to 'go the extra mile', which may not be practicable. There is a danger that we resort to a more 'textbook' approach as a defence against criticism. This led to a discussion about the real nature of the loving therapeutic relationship.

Love in the Time of Old Age

By Dr. Sarah Eagger

Love is a fundamental aspect of spirituality. There is so much one could say about Spirituality and Ageing and indeed, so much one could say about love. Where to begin? Most health settings now have guidelines for whole person care in which spiritual needs are acknowledged. However these are focused in specific ways for older people.

Spirituality

I will start with two definitions of spirituality to put the work done in old age psychiatry into context.

One brief but pithy definition is, *'The rediscovery of lost humanity'.*

The American National Interfaith Coalition on Ageing describes it as an *'affirmation of life in relationship with God, self, community and environment that nurtures and celebrates wholeness'.*

Values, relationships and the discovery of meaning and purpose in life - all these intangibles are of vital importance to us as human beings. This is what Spirituality is to do with.

Love

As healthcare professionals we may feel uncomfortable with the word, or the idea of, love. Maybe we feel easier describing 'love in action' - in other words, the effect of love in the kind of work we do – care, compassion, consideration, kindness, mercy, empathy and sympathy.

I have in the past been moved and inspired by the writings of Stephanie Dowrick (2000) and I would like to précis a passage from her book 'The Universal Heart'.

'It's clear that at the beginning of a human life and again at the end, love - expressed through delight, gratitude, constancy, interest, good humour, kindness - is what matters most to us. The absence of love is something that countless people experience on a daily basis. They may call it loneliness, isolation, dissatisfaction or emptiness. Often they have become strangers to love and strangers to themselves. Love joins us to others - we need that - the longing to care for others and be cared for is fundamental to our shared human nature. We are social beings, using our relationships throughout our lives to find out not only what we are capable of giving, but also to discover whom we are; what makes sense to us, what insight we can achieve, what kind of life we are in the process of creating. Love connects us and inspires us. Our well being as a society depends absolutely on whether we, as individuals, are willing to care about how life is for other people. A safe society is one where trust exists and concern for others is readily expressed. If we are cut off from our capacity to give and receive love, we go beyond loneliness, we become dangerous to others as well as ourselves. A life worth living is a life of love. And anything worth discovering about love will deepen not just one but every one of our relationships. Just as crucially, though, love joins us to the deepest part of ourselves. It allows us to know that our own life has legitimacy, that from our own inner world we can reach out to give willingly to other people and receive what they can give us.

Another publication that has inspired me is the 'Living Values' guide from the Brahma Kumaris World Spiritual University (BKSU 1995).

'Love is the principle which creates and sustains human relations with dignity and depth. It's the bedrock for the belief in equality of spirit and personhood. The basis of real love between people is spiritual. To see another as a spiritual being, a soul, is to see the reality of the other. To be conscious of that reality is to have spiritual love; each person, complete from within, independent yet totally interconnected, recognizes that state in the other. Love is not simply a desire, a passion, an intense feeling for one person or object, but a consciousness, which is simultaneously selfless and self-fulfilling. Love can be for one's

country, for a cherished aim, for truth, for justice, for people, for nature, for service, and for God. Spiritual love takes one into silence and that silence has the power to unite, guide and free people'.

Love as a Value

In 1994 the British Medical Association held a summit on 'Core values for the medical profession'. The summit called for a re-evaluation, redefinition and restatement of core values, which it defined as 'ancient virtues distilled over time'. Those at the meeting recognised these values - derived from the doctor-patient relationship and based on love, caring and sharing - as the profession's greatest asset, greater even than scientific knowledge and sophisticated technology.

The core values of the medical profession identified by that summit were *caring, compassion, integrity, competence, confidentiality, responsibility, advocacy and the spirit of enquiry.*

McWhinney (1998) writes that responding to suffering is a moral obligation, that compassion is not just conditional upon evidence of its effectiveness. The relationship between doctor and patient is a covenant, an undertaking to do what is needed, beyond the terms of the contract. Sticking with a person through thick and thin is hard work, an act of love - active love, tenacity - a whole science (or a whole art). The healing relationship between practitioner and patient carries strong moral obligations and mutual commitments. McWhinney feels we have forgotten the importance in medicine of *presence* and the continuity of responsibility.

Dr. Kieran Sweeney (2000) maintains that the relief of suffering is central to the responsibility with which we are entrusted. He believes trust and self–discipline are vital to this. Trust in others is one of the central human solutions to the unbearable uncertainty of being ill, and, indeed, for some the unbearable uncertainty of existence. Self-discipline implies a degree of self-knowledge. This helps us to recognise what the patient is experiencing and to have insight into the meaning of that experience for them as unique individuals.

Challenges of Old Age

As night follows day, so old age brings change and loss and with it dependency, isolation, loneliness and depression. But it can also be a time of great spiritual growth and awareness and for some, a celebration of wisdom borne of experience. People of all ages share basic humans needs; love, faith, hope, peace and worship. Older people are no different and certainly these needs can take on a particular poignancy in old age.

It is normal to view old age with some apprehension. The depletions of ageing multiply with the loss of role, bereavement and domicile. Undoubtedly they have an impact on 'personhood' in ways that we can but barely imagine when we are younger – our self-image and identity slowly drain away and ultimately we face death. Our society tends to be ageist and marginalizes older people, making them feel a burden. In western culture there is such an emphasis on achievement and the work ethic that there simply isn't the appreciation of wisdom of old age as an essential and significant ingredient of society. It would appear that in eastern societies it is more customary to respect and honour one's elders.

Yet, as the pastoral director of Methodist Homes for the Aged, Jewel (1999) reminds us, in the book Spirituality and Ageing, this is a time when the elderly have a real need for the affirmation of their continuing value as unique and socially connected human beings and their wisdom as a resource for others.

I recall here Erickson's eighth stage of psychosocial development – Integrity versus Despair (1982). According to Martindale (1998), integrity in old age is the capacity to assimilate (integrate) the value of one's full life experience, to be and to continue to be - through having been - able to hold onto the worthwhile aspects of one's life. These include conscious and unconscious memories of having been valued and loved. It implies being sufficiently free of persecutory guilt as a result of having been able to love.

Facing death also shapes the spirituality of many older people. The unfinished business of human relationships and the need to become reconciled with significant others becomes a high priority; the deepest desire is to die at peace. To try to heal painful memories and perhaps even the basic need to be at one with God (whom, or whatever, he, she or it might be) as death approaches is a legitimate focus. Towards the end of life there is the search for integration (a sense of wholeness in a spiritual sense), to pull life together and make sense of it as a whole.

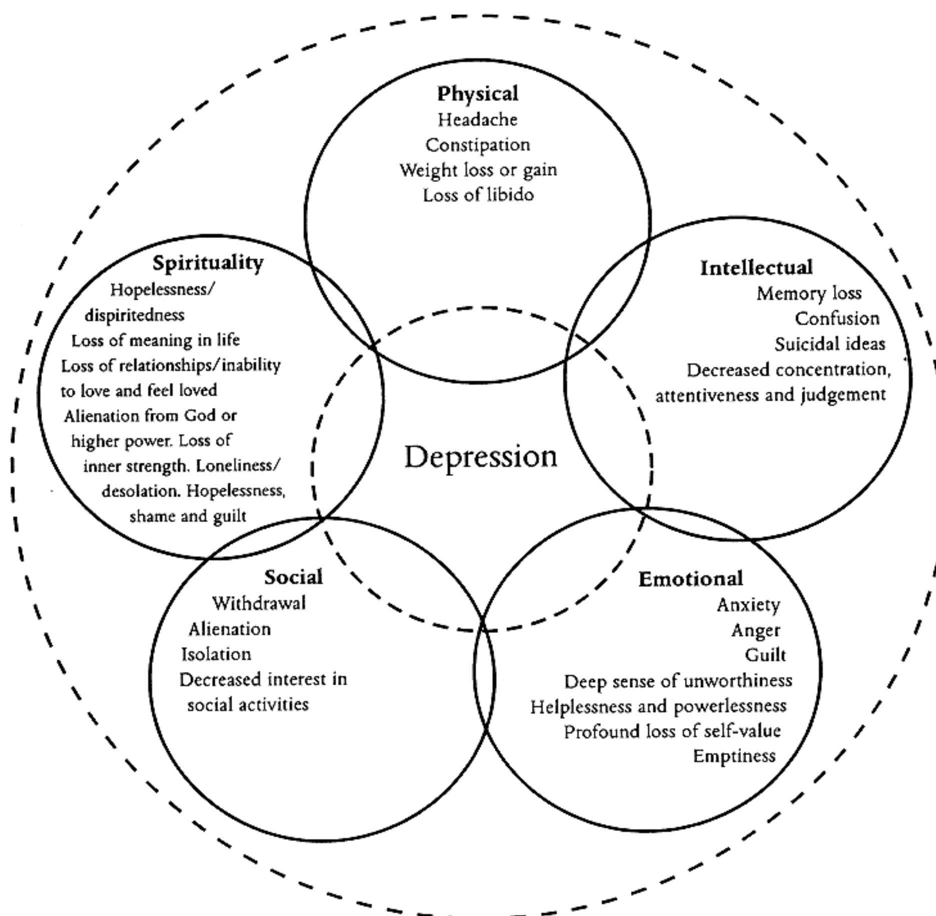
Old Age Psychiatry

In Old Age Psychiatry we deal with much co-morbidity. The elderly with mental health problems often have the triple disadvantage of problems associated with ageing, physical illness and mental ill health - depression, paranoia and dementia.

What of those who have 'turned their face to the wall' and feel there is nothing for them to live for anymore? Is this an illness requiring electro convulsive treatment, or a justifiable response to the end of life?

Swinton (2001), in his book Spirituality and Mental Healthcare, gives us a holistic model of the major disorders that incorporates spirituality.

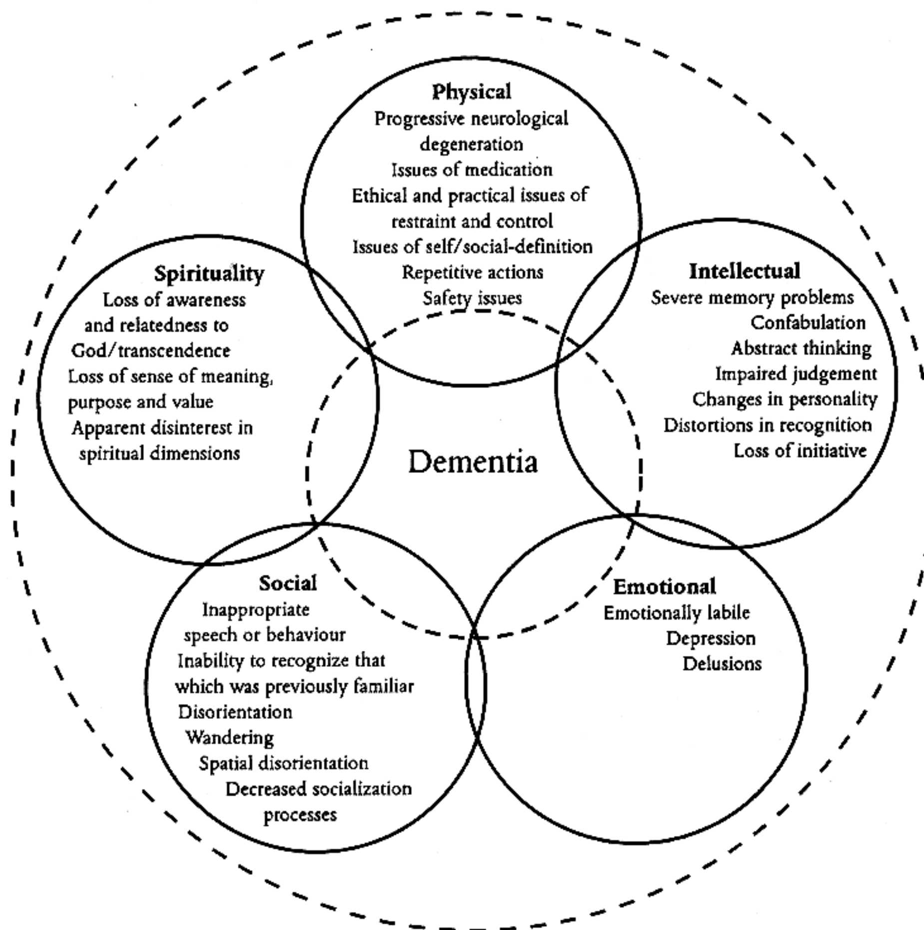
'Spirituality and depression' (Swinton page 167).



Swinton describes depression as a profoundly spiritual illness that digs to the heart of a person's spirit and forces people to face experiences of meaninglessness and hopelessness. We know that this can be devastating in its consequences. Swinton believes

the spiritual dimension has the potential to reframe experiences and enable people to reinterpret them in ways that are therapeutically helpful. He also believes that dementia provides us with the possibility of reframing from a spiritual perspective.

'Spirituality and dementia' (Swinton page 166)



When we ask the question 'what does it *feel* like to have dementia?' rather than simply 'what *is* dementia?' we begin to see this particular condition in a very different light. Swinton highlights work that has shown clearly the importance of recognising the continuing personhood of people with dementia, even in the midst of neurological degeneration. When viewed from the sufferer's perspective, dementia is found to have hidden psychological and spiritual dimensions that are masked by the dominance of the medico-biological discourse. Focusing on the former offers new possibilities of re-humanisation for people with this illness. Swinton encourages interventions such as a therapeutic presence that helps to *reconnect* those, who are by definition, becoming *disconnected* from self, others and God.

Certainly we are challenged to find spirituality capable of embracing dementia, a condition in which so much is stripped away that only the essence may seem to remain. This confronts our usual notions of personhood. I was extremely gratified to find that the late Tom Kitwood, a psychologist and leader in dementia care from Bradford, had put love at the centre of his circle of the main psychological needs of people with dementia in his book Dementia Reconsidered (Kitwood1997).

Kitwood also quotes a carer who described persons with dementia as showing 'an undisguised and almost child-like yearning for love'. By love is meant a generous, forgiving and unconditional acceptance, a wholehearted emotional giving without any expectation of direct reward. The presence of dementia, it is suggested, may provoke a psycho-spiritual

crisis in carers. *'If we do not deal with our own issues of love, and grief around the failures of love, we cannot live with Alzheimer's disease'.*

How we Love

I know that in our daily practice we reveal aspects of love in a myriad of ways. It is often the kind word, a touch or loving look that has the most significance for the patient. As Martindale describes (1998), we have an 'everlasting connection' with those who may have… nothing. At times we are the *only* human connection our patients have. We become their family, their world and, even immodest though it may sound, their reason to live. The rules of standard psychiatry seem to change, to become more flexible and respond in a humane way to the situations we face. We are there to affirm, validate, acknowledge, listen, witness, to hear confession, to hear their story, to love and allow ourselves to be loved. We help with the tasks of resolution and integration.

I recall a patient who was finding it difficult to come to terms with his loss of skills as a builder and I related the Daoist idea of the increasing value of quiet and reflection in old age. I told him that Daoists regarded it as one of the tasks of old age to sit beside running water and contemplate! He then realised how much time he spent sitting by his fishpond and how much he enjoyed it and was delighted.

We talk about facing death. The disclosure of hitherto well-guarded concerns will only occur if the therapist creates a climate of trust and is non-judgemental. What enables trust and the unspoken to be spoken?

My colleague Dr. Mark Ardern (2001) in his chapter on 'Dynamic psychotherapy in the setting of the old age psychiatry department', states that such therapy is most likely to be supportive. He goes on to describe how a basic premise is that the patient's ego is insufficient to allow personality change and the prospect of insight is limited. One aim of supportive psychotherapy is to locate weaknesses in the patient's defensive structure and bolster these by the therapist's active encouragement. The therapist still constructs a psychodynamic formulation to avoid alienating the patient or precipitating psychiatric illness. Therapists observe the transference and counter-transference but by and large keeps these ideas to themselves.

It is assumed that the major factors in the success of supportive psychotherapy are the therapists' reliability and empathy. As the patient's unconscious preoccupation is with impending dependence, the dependability of the therapist is especially crucial for the elderly. Patients may not need to be seen frequently, but for the internalisation of the good object will have to be sure that the therapist is psychically available. For some patients the therapist may conclude that weaning away is not possible. In these cases the patient's dependence is actively cultivated. The notion of encouraging dependence can seem alien to other branches of psychiatry. In these situations, we also try to foster a dependence on 'the team', so that a *community* is available, rather than the burden having to be placed on a single individual. Patients can experience a new kind of parenting that provides containment.

In group therapy for older people, they are also able to show concern for each other. In these groups the process of pairing does not have to suggest destructive sub-grouping but can be of self-restorative value. There are also potential benefits in extra - group socialisation and it is often unavoidable. Group psychotherapy with older people is likely to require a greater tolerance of behaviours. In a mature group some patients will act as co-therapists, not necessarily a defensive manoeuvre.

Generally speaking, the emphasis of our work moves from one of change to acceptance. We are co-workers in the task of rearranging the bricks that make up the architecture of character, rather than replacing them.

In his book Spirituality and Ageing, Jewell (1999) remarks that we so often hear old people say 'Why don't I die? I don't want to be a burden to others'. He feels we should never allow this to go unanswered as it signifies hopelessness. Instead, he tells old people *'you are never a burden if people love you. Those who do, have the joy and privilege of looking with tenderness, concern and intelligence at someone they love. But in return you*

must be able to receive graciously and make it as easy as possible for them to love you. If you receive with a cramped heart you are saying 'I would prefer to receive nothing from you but I am a victim".

We all depend on one another's love and must learn at all ages how to receive it with gratitude and grace.

All patients are vulnerable, ours especially so. They often can't communicate in the conventional sense, yet really respond to our loving attitude. I don't have to tell you that this is not easy to sustain, day in day out, with the sheer intensity of the work. I continuously see how much love is reflected in work we do in dementia care.

I would like to relate a further passage from Stephanie Dowrick's book 'The Universal Heart' that illustrates this point.

'I was told a quite exceptional story about two people I have observed together on several occasions. The younger man Geoff is profoundly intellectually and physically disabled. He has no speech. His movements are limited and out of control. He is also deaf and blind. The older man Bill is the volunteer, who comes unfailingly each day to see Geoff, to talk to him, hold his hand, share news with him and let him know he is loved. Nothing too remarkable in that you may think. But what about this? When Bill enters the large building where Geoff lives, Geoff starts moving, smiling, and making the noises that are for him the nearest approximation to speech. He cannot hear Bill coming, but through his senses he knows that Bill is in the building, even when Bill is still several rooms away. Geoff is someone whose powers of comprehension would seem to be minimal. Yet the sense that he has of Bill's presence, and the comfort and delight he draws from that, is unfailingly acute.'

This really does demonstrate the mysterious power of love and it's central role in caring. I see this on the wards every day.

The team

A team with high morale and a clear sense of purpose is inherently of benefit to patients. One that is split, and at war with itself, will lead to patients being caught in the middle. Our ability to care depends to a large extent on our own experience of being cared for and valued. As well as being loving practitioners, we need loving institutions. This could also go some way towards protecting patients from practitioners acting out their own needs in the healthcare setting, for instance, the need for power, control, to be liked, wanted and cared for. These needs can be more healthily contained in an atmosphere of good staff support.

We need to care for and love each other. A very touching experience for me in our unit was after the death of a staff member's young child. The staff group held a spiritual service where each contributed a ritual and spoke to support the mother and acknowledge their own grief.

It may be easy to talk about love but a relevant question for all of us is how to be compassionate in caring for our patients without personally becoming emotionally drained, compassion-fatigued or 'burned-out'. By burnout, I mean a state of physical, emotional and mental exhaustion caused by long-term involvement in situations that are emotionally demanding.

Learning to be compassionate without suffering burnout is a skill. Compassion is something that we all innately posses, yet we need to practise and refine its use. It is learning to be alongside patients in their suffering by seeing them as souls like ourselves and yet at the same time not to identify personally with all their physical, mental and emotional issues. It is remaining emotionally detached from patients, yet keeping a spiritual, loving connection.

Finally, we can only be compassionate towards others if we have the same compassion towards ourselves. This means nourishing ourselves at all levels, physical, mental and spiritual. How do we do this - how can we allow compassion to flow in from others, and from the universe, to replenish ourselves from a spiritual filling station, as it were? How can we tap into a source of love and mercy and keep ourselves topped up? Surely this is what spiritual practices offer, such as prayer, devotion, meditation and

contemplation.

What patients say

A patient told me 'Love from you means not to be shunned, that you listen to me, I'm not cut off, that you are concerned about me and kind - it may even be physical, such as touching me on the arm in a reassuring way, or holding me in your mind.'

I've come to realise many aspects of love through my own work running a support group for people in the early stages of dementia. When asked whether patients in the group ever think about God, their quick replies reveal their preoccupations. 'What I want to know,' asks one, ' is not whether we think about God but does God think about us?' Another patient said, 'No one asks you how you are going to prepare to meet your God'.

In groups we have the privilege of hearing the anxieties and frustrations of older people that would not normally be discussed in a social setting. Some of our patients in the day hospital requested that we acknowledge the passing on of some of the patients. We assisted them in their own plan of having a small service on All Souls Day, having a book of condolences and a bench in the day hospital garden to commemorate those that had passed on. It was not just a memorial to those departed or reassurance that they too would be remembered when their turn came. This acknowledgement of their spiritual needs was also an act of love.

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Discussion on Love in the Time of Old Age. Reported by **Dr. Daphne Wallace**

It was voiced that there is a danger of 'compassion burnout' and the need for refreshment for the self, which may be through various means including prayer or meditation. It was suggested that in Old Age Psychiatry we are privileged to be able to respond to neediness and dependency. It was noted, however, that recruitment into work with older people is not good, especially in nursing. Possibly the professionalisation of nursing has made the situation worse by increasing the distance between nurse and patient.

In the discussion that followed, the assessment of spiritual needs was discussed at length with reference to the work of Michael King and to the Handbook of Religion and Health, edited by Koenig, Larsson and McCulloch. It was suggested that measurement

scales were useful, as a door opener to introducing spiritual needs into mental health curricula. It is hard to offer love when faced with rejection and criticism, not least from colleagues. In particular, there is the danger of collusion with the patient's view of self as a failure with nothing to give. Each person has it in them to love but we find that difficult to communicate. Equally, it's important not to feel guilty at what we can't do.

The Mindfulness-Based Stress Reduction Programme

A Workshop conducted by **Dr. Jon Kabat-Zinn**, August 2001, Bangor, Wales

Reported by **Dr. Maya Spencer**

Through the 1980's and 90's, Dr. Jon Kabat-Zinn and his team at the University of Massachusetts Medical Centre have quietly been setting the stage for a revolution in medicine. Hundreds of outpatients have learnt to meditate as part of their medical treatment by going through the Mindfulness - Based Stress Reduction Programme, held in a specialist clinic within the department of medicine. In August 2001 Dr. Kabat-Zinn and the present director of the clinic, Saki Santorelli, came over to the UK to present their work in an experiential 5-day workshop at Bangor University, aimed primarily at health professionals.

The mindfulness-based stress reduction (MBSR) programme is an 8-week course in which patients attend a weekly class where they are instructed in mindfulness meditation (sitting and walking), yoga, and the body-scan technique. They commit to meditating in one or other of these modes at home, for 40 minutes a day, 6 times a week. They also have other homework. The beauty of mindfulness meditation is that it can be generalised to whatever one is doing in the moment, so it is possible to take a shower mindfully, to do the washing up mindfully etc. – or so I am told, I haven't achieved it yet! Mindfulness simply means non-judgmental, moment-by-moment awareness - of thoughts, feelings, and sensations. It develops concentration, and the faculty of witnessing - as opposed to being caught up in - mental activity.

In the Bangor workshop, we received similar instruction as in the stress reduction classes, and *our* commitment was to start each day with sitting meditation at 6 am. Afterwards, we divided the time between meditation and yoga practice periods, with time also given to question and answer sessions with Jon and Saki. I can't make much comment on the body scan technique other than to say it was extremely relaxing as I went to sleep each time! In fact, it is not a relaxation technique, but requires one to focus the attention on physical sensations during an inner tour of the body.

It was an intensive programme with evening sessions as well. One evening Jon gave an inspiring account of how the mindfulness-based programme developed, and has spread not only around North America, but also to other parts of the world. Another time, he gave a summary of the considerable amount of research that has been carried out, which shows the effectiveness of the programme. One of the appeals of his work is that it has a strong evidence-base. Most riveting, of course, were the moving accounts of patients' experiences and responses to the programme.

There were around one hundred participants in the workshop, with about two-thirds coming from Holland and Germany. It was held in a large hall, and it is a tribute to Jon and Saki that they overcame the impersonal space and a poor PA system to create a

wonderfully intimate atmosphere. They did this by being ordinary, fallible human beings to a degree that is extraordinary in my experience of academic events. Their sincerity and utter dedication to their work was deeply impressive. They both participated with us at all times (yes, even at 6 a.m.) and it was plain that being present with us, including mealtimes and the walks back to the accommodation site for meals, was their priority. Their depth of experience with both meditation and patients carried an unassailable conviction: they do indeed 'walk their talk'.

Is there a place for similar programmes here, in the UK, in psychiatry? Bearing in mind that the University of Massachusetts clinic takes patients who are referred by physicians, it is important to realise that the Stress Reduction Programme caters for patients who are in the domain of liaison, not general, psychiatry. The centre is staffed by clinical psychologists. Research showing benefits of the programme to patients with anxiety and depression was carried out with medical, not psychiatric, patients with these conditions. Dr. Santorelli told me of some exciting pioneering work by a psychiatrist in another state, who is adapting the programme for people with schizophrenia, but this seemed to be an isolated example of its application within the field of severe mental illness.

It was hard to imagine the transposition of the programme into the NHS in Britain, and others I spoke to felt the same. It requires a high level of commitment to making a major life style change, and often that commitment seemed to come from feeling that all avenues of medical treatment have been tried without success, that MBSR is the last hope. Research has shown that benefit from the programme correlates with time spent meditating at home, not with clinic attendance (1). One of the most encouraging aspects of the work with the programme has been its success with an inner city, Spanish-speaking population (2). For them, yoga was called 'gentle stretching' and meditation was 'relaxation', to make the programme more acceptable.

The one place with significant experience of trying out the programme over here is Bangor, where the community mental health team have linked in with research being carried out in the University into a possible marriage of mindfulness meditation with cognitive therapy. The experience is predominantly positive, as has been demonstrated in a multi-centre clinical trial involving John Teasdale's group in Cambridge and another centre in Toronto (3). For those interested in this development within cognitive therapy, a book will be coming out in November 2001, entitled *Mindfulness-Based Cognitive Therapy for Depression,* and endorsed by Aaron Beck. An interesting finding has been that the programme seems to work best for those with several episodes of recurrent depression, perhaps pointing again to the prime importance of failure of conventional treatment in motivation for compliance with mindfulness practice.

Jon made it plain that an MBSR programme can only be run by people who consistently practise mindfulness themselves. Training requires people to have meditated consistently for at least three years before starting. It would be interesting to know how big a pool of regular meditators there are in the health service in the UK, but on the face of it this stringent, though obviously necessary, requirement appears to preclude the spread of similar programmes over here, before we even start on funding issues. Once again we are faced with the great divide between those with traditional skills who have professional access to patients, and those who have developed other personal resources that could help people help to themselves more effectively, but who find little invitation to join with a health service that still often regards them with suspicion and condescension. The MBSR programme has successfully bridged the gap, and appears to me to fit best over here in a primary care context, in the development of self-help programmes for those patients with significant illness or distress whose psychological needs generally fall outside the remit of the community mental health team and are currently very poorly attended to by the NHS.

Jon Kabat-Zinn has achieved what few do: he has set up an innovative programme in the field of mind-body medicine that has been accepted by general hospital physicians, and that has been of enormous value to large numbers of patients. He has confirmed this value with sound research. He has inspired others to emulate him, and his work has spread internationally. He has brought spirituality to the forefront of medicine in a way that is independent of religious affiliation and acceptable to all. It was a privilege to attend his

workshop, as well as a beneficial experience both personally and professionally. I couldn't resist a little mischievous smile while doing my yoga stretches to think this was actually paid study - leave! That's definitely progress towards bringing spirituality into psychiatry.

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Recommended reading

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SPECIAL GUEST CONTRIBUTION

Patient Spirituality and Mental Health:
A New Focus in Clinical Care and Research

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Introduction

Patient spirituality, a once disregarded dimension, is emerging in research and clinical care as a relevant factor in mental health. Internationally, psychiatry's professional associations have highlighted the need for developing sensitivity to this life dimension. A growing number of U.S. psychiatric residencies now include training on how to address

patient spirituality in clinical care. Quantitative research in the last 15 years in the U.K, the U.S., and other countries has discovered aspects of this complex dimension generally linked with beneficial mental health outcomes.(1,2) Research has also helped clarify aspects of negative religious coping.(3) This two-part article summarizes some of the changes in focus, clinical education, and assessment in the field of psychiatry, as well as reviews research findings investigating spirituality and mental health. Part I discussed the growing professional recognition of spirituality as a relevant mental health factor in clinical care and research, and noted changes in residency training and clinical assessment to include patient spirituality.

Part II: A Brief Review of Research Findings on Spirituality and Mental Health

Religious/spiritual vitality and its potential salutary links with emotional health emerge in recent research findings as a relevant clinical factor. Research is finding associations that may help prevent depression and addictions, help patients cope with severe physical or mental illness, and in some instances help in recovery.(3) Published research has also helped to identify negative religious coping patterns with potential harmful effects to mental health status.

Many mental health professionals remain unfamiliar with the large, growing body of research findings, especially those linked with beneficial clinical relationships. Introduced in their psychiatric training to the harmfulness of religion/spirituality, many are skeptical about potential mental health benefits of religious practices or beliefs. This skepticism may be supported by valid clinical concerns about the apparent ill effects from the conflictual use of religion by those with mental illness in negative religious coping.(4) Yet studies in the last 20 years have uncovered aspects of positive religious coping linked with clinical mental health benefits, briefly reviewed below.

A Consensus Report in the U.S. culminated the collaboration of more than 70 researchers, clinicians, and ethicists in the fields of physical and mental health, addictions, and the neurosciences to evaluate the research field of religion/spirituality and health. These researchers, many of them initially unaware of the extensiveness of the quantitative research, met three times over 18 months to review current research findings. They also mapped out future directions and identified barriers to overcome in investigating the links between spirituality/religion and physical and mental health. The 1998 report concluded that the data from many of the studies conducted to date are both sufficiently "robust and tantalizing" to warrant continued and expanded clinical investigations.(5)

Briefly summarized below are peer-reviewed published studies in the areas of 1) prevention, coping, and recovery from depression, 2) suicide prevention, 3) substance abuse prevention and treatment, 4) adolescent and adult health risk reduction, 5) coping with surgery and severe medical illness, 7) potential harmful aspects of spiritual/religious problems, and 8) religious/spiritual links with longevity.

(For an extensive overview, the Handbook of Religion and Health, Oxford University Press 2001, reviews more than 1,200 published research studies, providing findings on the positive and negative relationships of spirituality and religion on physical, mental, and social health from childhood to old age.1 For research summaries and reviews and other resources, please also visit the International Center for the Integration of Health and Spirituality website: www.ICIHS.org.)

Prevention, Coping, and Recovery from Depression: Spirituality as a Protective Factor

A review of more than 80 studies published over the last 100 years found religious/spiritual factors generally linked with lower rates of depression. (6) Persons who both participated in a religious group and highly valued their religious faith were at a substantially reduced risk of depressive disorder while people with no religious link may raise their relative risk of major depression by as much as 60%.

Lack of organizational religious involvement was linked with a 20-60% increase in the odds of experiencing a major depressive episode. The authors suggested that valuing

one's religious faith as centrally important and actively belonging to a religious group may give a spiritual basis for meaning as well as support from others, potentially providing hope and caring which might also aid in protecting against depression.

A comprehensive study with a one-year follow-up in the Netherlands found that people who indicated that "a strong religious faith" was one of the three most important factors in their life had only 38% the odds of becoming depressed in comparison with those who did not ascribe such importance to their religious faith.(7) Also, among those who were depressed at the beginning of the study, those who ranked their religious faith as highly important recovered faster from their depression.

Similarly, in the U.K. an epidemiology study found attending church and a "vital religion" were protective factors from vulnerability to depression in both an urban and a rural community.(8)

However, another U.S. study found religious coping was associated with lowering only certain types of depressive symptoms. Loss of interest, feeling of worthlessness, withdrawal from social interaction, loss of hope, and other "cognitive" symptoms of depression were significantly less common among patients drawing upon religious beliefs or practices to cope. Yet "somatic" symptoms such as weight loss, insomnia, loss of energy, and decreased concentration appeared unaffected by religious coping. The investigators concluded that religious coping may reduce the affective symptoms of depression, but appeared less effective for the biological symptoms that might be more responsive to pharmacologic treatments.(9)

Spirituality and Depression Treatment Outcomes

In a U.S. treatment study concerning moderate depression, an intervention drawing upon personal spiritual resources also hastened recovery. Among religiously committed patients, those receiving religiously oriented cognitive-behavioral therapy had better scores on measures of both post-treatment depression and clinical adjustment than those whose therapy omitted religious content.(10)

The religious therapy employed included religious rationales, religious arguments to counter irrational thoughts, and religious imagery. Therapy with religious content resulted in significantly faster recovery from depression -importantly, whether the therapist was religious or not. This somewhat surprising finding illustrated the potential for non-religious therapists to effectively conduct therapy with religious content for religiously committed patients.

Similarly, a study of 62 Muslim patients with generalized anxiety disorder were randomized to receive either a traditional treatment of supportive psychotherapy with anxiolytic drugs or traditional treatment with medication plus psychotherapy with religious content, involving patient prayer and reading verses of the Holy Koran specific to the person's clinical condition. The study reported that patients receiving psychotherapy with religious content showed significantly more rapid improvement in anxiety symptoms than those receiving traditional therapy that did not include it.(11)

Recovery from Depression among the Medically Seriously Ill

Depression often strikes older patients hospitalized for medical illness. While major depression afflicts only 1% of older adults living in the community in the US, the figure rises to 10% among medically ill hospitalized elderly. Some 35% or more with medical illness suffer with less severe types of depression.

Researchers at Duke University investigated whether religious coping resources might help patients recover faster from their depression. The research team used multi-dimensional measures including questions about frequency of religious attendance, and private religious activities like prayer or Bible study. They also employed Hoge's 10-item validated scale to measure patient levels of intrinsic religious commitment. "Intrinsic" pertains to what extent a person takes their religious beliefs to heart as a major motivating factor in their decisions and behavior. The study sample included 87 depressed older adults hospitalized with medical illness. The course of their depression was tracked for almost a year. Somewhat surprisingly, for every 10-point increase in intrinsic religion score in the 50-

point scale, there was a 70% increase in their speed of remission from depression. This effect remained after controlling for multiple demographic, psychosocial, physical health, and treatment factors.(12)

In another study of 850 elderly men admitted to the hospital, researchers found that patients who used their religious faith to cope were significantly less depressed.(13) In a subgroup of 201 patients, the extent of their religious coping predicted lower depression scores on follow-up six months later. Furthermore, the clinical effects of religious commitment were strongest among those with most severe levels of disability.

Spirituality's Role in Suicide Prevention:

Religious participation reduces risk of suicide. Both a recent large U.S. national study as well as an initial large-scale regional study published thirty years earlier found that persons who did not attend religious services were four times more likely to kill themselves than were frequent religious attenders.(14,15)

Furthermore, in a review of 68 studies that examined the relationship between suicide and spirituality/religion, 84% found lower rates of suicide or more negative attitudes toward suicide among the more religious.4

A study of U.S. adolescents found religious commitment significantly reduced risk of suicide,(16) an especially significant finding in the face of a 400% rise in teen suicides in the U.S. from 1950 to 1990, according to the National Center for Health Statistics.

In a study of suicide rates in the Netherlands, a decrease in suicide mortality was linked with a religious revival among the young, pointing to religion/spirituality serving as a protective factor.(17)

Older persons who died by suicide when compared with those who died a natural death were less likely to have participated in religious services during their lifetime, found an analysis of a U.S. National Mortality Followback Survey of 5,000 deaths. (29)

Adjusting for sex, race, marital status, age, and frequency of social contact, the analyses showed that visiting or talking with friends or relatives did not reduce the likelihood of suicide compared to death by natural causes, but frequent participation in religious activities did. The researchers suggested these findings showed it may not merely be the social contact inherent in some forms of religious participation that decreases suicide risk, but something else more inherent in spirituality and religion . They concluded, "Participation in religious activities may act as a safeguard against suicide."

Nevertheless, a 1994 evaluation of suicide assessment instruments in the U.S. observed that "although religion is noted as a highly relevant factor in suicide literature, the number of religious items included on assessment scales approaches zero." The review noted the need to begin to recognize and include religion/spirituality in suicide prevention, treatment, and care,(18) especially given the increasing suicide rates among adolescents and the elderly.

Substance Abuse Prevention and Treatment: Drug Abuse Prevention:

The lack of religious commitment arises in research findings as a risk factor for drug abuse.

A review of nearly 40 studies found that people with higher levels of religious commitment were less likely to become involved in substance abuse.(19) These findings supported other reviews, which found that lack of religious commitment stood out as a predictor of those who abuse drugs.(20)

Another survey of almost 14,000 U.S. youths found that analysis of six measures of religious commitment and eight measures of substance abuse showed religious/spiritual commitment was linked with less drug abuse. In this study, the measure of "importance of religion" to the person was the best predictor in indicating lack of substance abuse, implying that the controls operating were internalized values and norms rather than fear or peer pressure.(21)

Drug Abuse Treatment:

Drawing upon spiritual resources can also make a significant difference in outcomes in effective drug treatment.(22) For instance, in the U.S. 45% of participants in a religious outpatient treatment program for opium addiction were still drug free one year later compared to only 5% of participants in a non-religious public health service hospital inpatient treatment program-a nine-fold difference.(23)

Prevention and Treatment of Alcohol Abuse:

Parallel to reducing use of illicit drugs, spiritual/religious involvement similarly predicts fewer problems with alcohol.(24)

A systematic review found 86 studies that examined spiritual/religious commitment and alcohol use. Some 88% found lower alcohol use/abuse among the more religious, including the high risk group of adolescents and young persons.(4)

U.S. studies reveal that persons lacking a strong religious commitment are more at risk to abuse alcohol. Risk for alcohol dependency is 60% higher among drinkers with no religious affiliation compared to members of conservative denominations.(22)

Religious involvement tends to be low among those diagnosed with alcohol abuse.(25) A study of the religious lives of alcoholics found that 89% of alcoholics had lost interest in religion during their teenage years.(26) Alcoholics often report having had negative experiences with religion and hold concepts of God that are punitive, rather than loving and forgiving.(27)

Furthermore, a relationship between religious/spiritual commitment and the non-use or moderate use of alcohol has been documented. One study found somewhat surprisingly that whether or not a religious tradition specifically teaches against alcohol use, those who are active in a religious group consumed substantially less alcohol than those who were not active.(28)

Once alcohol addiction has taken hold, spirituality is often a powerful force in achieving abstinence. Alcoholics Anonymous (AA) invokes a Higher Power to help alcoholics recover from addiction. Those who participate in AA are more likely to remain abstinent after inpatient or outpatient treatment.(29)

Smoking Prevention:

Most smokers in the U.S. begin as teenagers or young adults, with about a third quitting by the time they reach 65. An initial study of smoking and religious activity in older Americans found the life-long, strongly religious are much more likely never to have smoked at all. Also, the elderly who actively participated in their religious faith were 90% less likely to smoke. Among those older adults who did smoke, the number of cigarettes smoked per day sank significantly among the more religiously active.

Frequently attending religious services stood out as the most important religious factor linked with less smoking in this study. Private study of scripture and prayer didn't show nearly as strong a link. Watching religious TV or listening to religious radio had no connection to smoking reduction.(30) Also, not only potentially effective in prevention, religious/spiritual involvement is associated with higher success rates in smoking cessation treatment.(31)

Reducing Adolescent Health Risks:

A U.S. national study of 5,000 high school seniors found those who both attend church weekly and report that religion is important to them are much less likely to engage in binge drinking, smoking, or using marijuana, are less likely to carry weapons or get into fights, and more prone to eat in a healthy fashion, to exercise regularly, get adequate sleep, and wear seat belts, researchers found after controlling for sociodemographic factors.(32)

Relative to their peers, religious youth are less likely to engage in behaviors that compromise their health, suggesting that religious resources may serve as a potentially important, often overlooked, ally in promoting health.

Reducing Health Risks among Adults:

In a 30-year U.S. community study published in 2001, persons who at the start of the study attended religious services weekly were more likely to both improve health behaviors and maintain good ones than those whose attendance was less or none at the start.(33) These included starting to exercise, quitting smoking, increasing social contacts, and maintaining marital stability. Weekly attendance was also linked with improved mental health status including reduced depression.

Confirming other studies showing reduced depression and substance abuse, a study of 1,900 women twins published in the American Journal of Psychiatry found significantly lower rates of major depression, smoking, and alcohol abuse among those who were more religious.(34)

Coping with Surgery and Serious Medical Illness:

Seriously ill patients or those undergoing surgery face high stress and have potential mental health needs. Resources for coping contribute to dealing with the potential anxiety and risk of depression these patients may face when dealing with medical illness. Studies on what helps patient cope identify spiritual/religious commitment as a significant resource.

Recovery from Surgery:

A study at Dartmouth Medical School found that elderly heart patients were 14 times less likely to die following surgery if they found strength and comfort in their religious faith and also were socially involved in organizations. In this study of 232 patients, those who said they derived no strength or comfort from their religious faith had almost 3 times the risk of death at the 6-month follow-up as patients who found at least some strength. None of those who saw themselves as deeply religious prior to surgery had died six months later, compared to 12% of those who rarely or never went to religious services.(35)

Another study of elderly women recovering from hip fractures also found patients' religious commitment enhanced recovery. Women to whom God was a strong source of strength and comfort and who frequently attended religious services were less depressed and could walk farther at discharge than patients who lacked a strong spiritual/religious commitment.(36)

Coping with Cancer:

A survey of 108 women undergoing treatment for various stages of gynecological cancer found that 93% of these cancer patients said their religious lives helped them sustain their hopes. Some 75% said religion had a significant place in their lives, and 41% noted their religious lives supported their sense of worth. Almost half (49%) felt they had become more religious following the onset of their cancer.(37)

Negative Religious Coping:

At times aspects of spiritual/religious commitment can be linked with negative physical or mental health outcomes, hindering rather than helping treatment and recovery:

Research has revealed that beliefs of certain religious groups who reject medical interventions for their children for "faith healing" can lead to earlier death from often-treatable diseases.(38)

Elderly ill patients' reports that they felt alienated from or unloved by God and attributed their illness to the devil were associated with a 19% to 28% increased risk of dying during the 2-year follow-up period, after controlling for demographic and physical and mental health variables.(3)

Negative religious coping, such as seeing illness as a punishment from God or questioning God's power or love was linked with more depression, poorer quality of life, and callousness towards others in a study of hospitalized patients.(39)

Another study described individual psychopathology linked with families whose rigidity, enmeshment, and emotional harshness were supported by enlisting religious beliefs or views.(40)

Spirituality's Links with Living Longer:

In contrast to the above finding of risk of earlier death among elderly ill with spiritual distress, many studies find active religious involvement increases potential longevity.

A meta-analysis of all published and unpublished studies examining religious involvement and death by any cause summed 42 study samples totaling nearly 126,000 people and found active religious involvement increased the chance for living longer by 29%.(41) Participating in public religious practices like worship attendance increased the chance for living longer by 43%. The analyses revealed the links were so strong it would take 1,400 new studies showing no association between religious involvement and living longer to overturn them.

Attending religious services more than once a week stretched lives an average of 7 years for whites and added a potential 14 more years for African Americans in a U.S. study in Demography which tracked a national sample of more than 21,000 US adults for nine years.(42)

A study in the American Journal of Public Health in 1997 found persons who attended religious services weekly or more were 25% less likely to die in the 28-year study period than infrequent attenders.(43) For women, the protective effect of attending services was stronger than choosing not to smoke, and stronger for men than exercise.

To assess whether these findings might be explained by the possibility that persons in better health are more likely to attend religious services than those who are sick or disabled and thus unable to attend, the study found persons with significant impairment in mobility were in fact more likely to be frequent attenders. Improved health practices, increased social contacts, and more stable marriages occurred more often for those who frequently attended worship services. Better health practices did help contribute to but did not fully account for the lower mortality rates.

The study examined and controlled for numerous social, economic, and health and lifestyle factors, as well religious attendance, to see who was most likely to avoid death by any cause. Religious attendance surfaced as a strong predictor for living longer, even when statistically controlling for other relevant factors

A 16-year study in Israel found distinctly lower rates of early death in religious kibbutzim compared to those living in secular kibbutzim, evident in both genders, at all ages, and consistently over all causes of death. Interestingly, the magnitude of the protective religious effect eliminated the usual gender advantage: secular women did not live longer than religious men.(44)

Summary:

Published research has found links between spirituality and beneficial mental health outcomes in the areas of prevention, coping, and recovery from depression; suicide prevention; substance abuse prevention and treatment; and in enhancing adolescent and adult health behaviors. Religious coping can positively help patients dealing with surgery, or with severe or chronic medical or emotional illness. Longitudinal studies have found frequent spiritual/religious practices such as attending religious meetings weekly or more is linked with living longer. Other studies have shown negative religious coping in which God is seen as punitive or abandoning may have adverse mental health outcomes and risk of earlier death.

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Next Programme for Members of the SIG, to be held at the Royal College of Psychiatrists on 1st February 2002

‘GOOD AND EVIL – THE CHALLENGE FOR PSYCHIATRY’

10.15	Coffee
10.45	Preliminary notices: Dr. Andrew Powell (Chair)
11.00	‘**Capacities and Dispositions – reflections on good and evil from a forensic psychiatrist’.** **Dr. Gwen Adshead** Consultant Psychotherapist, Broadmoor Hospital, Consultant Psychiatrist, Traumatic Stress Clinic, UCL. Chair, Philosophy SIG.
11.45	Discussion
12.30	Lunch
1.45	**‘Is Evil necessary? - The psychology of religious belief’.** **The Right Revd. Dominic Walker**, Bishop of Reading. Member of the Church of England Working Party on the Ministry of Healing
2.30	Discussion
3.15	Tea
3.30	**‘Does Evil have to exist to be real? - The discourse of evil and the practice of mental health care’.** **The Revd. Dr. John Swinton**, Senior Lecturer in Practical Theology, University of Aberdeen.
4.15	Discussion
5.00	End of meeting

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Reply Slip to be returned to Sue Duncan at the College

I wish to attend the next meeting of the Spirituality SIG on Good and Evil – the Challenge for Psychiatry on Friday 1st February 2002 and enclose the registration fee of £15, payable to The Royal College of Psychiatrists **(includes coffee, lunch and tea).**

Please ring your lunch preference: Vegetarian / Non-vegetarian

Name: (Capitals please)**…………………………………………………………**

Contact phone number……………………………………………………..

Please note the closing date for this meeting will be Friday, 25th January.

Advance Notice of Open Joint Meeting of the Psychiatry Section of the Royal Society of Medicine and the Spirituality and Psychiatry Special Interest Group

THE PLACE OF SPIRITUALITY IN PSYCHIATRY

Tuesday 14 May 2002
9.00 am – 5.00 pm

To be held in the Barnes Hall at the Royal Society of Medicine
1 Wimpole Street, London, W1G OAE

9.00 am	**Registration and coffee**
	Chair: *Dr Dinesh Bhugra, President, Section of Psychiatry*
9.30 am	**Introduction from the Chair**
9.40 am	**Putting the soul into psychiatry**
	Dr Andrew Powell, Chair, Spirituality and Psychiatry Special Interest Group
10.10 am	**Reflection, discussion and questions**
10.30 am	**Coffee**
11.00 am	**Spirituality, music and psychiatry**
	Rev Alison Kennedy, East London and the City Mental Health NHS Trust
11.30 am	**Reflection, discussion and questions**
11.50 am	**Spirituality in psychiatric education and training**
	Dr Robert Lawrence, St George's Hospital Medical School, London
12.20 pm	**Reflection, discussion and questions**
12.45 pm	**Lunch**
	Chair: *Dr Sarah Eagger, Imperial College School of Medicine*
2.00 pm	**Welcome from the chair**
2.05 pm	**Spiritual and cultural care in East London**
	Dr Nigel Copsey, East London and the City Mental Health NHS Trust
2.35 pm	**Reflection, discussion and questions**
2.55 pm	**The place of spirituality in psychoanalytical psychotherapy**
	Ms Sue Irving, St George's Hospital Trust, London
3.25 pm	**Reflection, discussion and questions**
3.45 pm	**Tea**
4.15 pm	**Plenary, with all speakers**
5.00 pm	**Close of meeting**

The meeting is eligible for 5 CPD points (Royal College of Psychiatrists)

Please return your completed registration form by Wednesday 8 May 2002

REGISTRATION INFORMATION

Joint meeting of the Section of Psychiatry and the Psychiatry and Spirituality Special Interest Group	**Office use only** Received:
The place of spirituality in psychiatry Tuesday 14 May 2002 Venue: Barnes Hall	Delegate: /1496 Finance: 40-0-31-033-01 Publicity:

Please fill in your name and present appointment and institute as you would like them to appear on the delegate list, your name badge and the attendance register.

Please use one form per person, feel free to photocopy.
Please complete in BLOCK CAPITALS

Name (title, forename, surname) ....

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Present appointment & institute ....

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Please return your form by Wednesday 8 May 2002 to:
Ruth Cloves, Academic Department, Royal Society of Medicine, 1 Wimpole Street, London, W1G 0AE
Tel: (+44) (0) 20 7290 2985, Fax: (+44) (0) 20 7290 2989
email: psychiatry@rsm.ac.uk
Book on-line at: www.rsm.ac.uk/*psychiatry*

Registrations will not be accepted over the telephone. Places are only guaranteed upon written confirmation. Acceptance onto this meeting is at the discretion of the meeting organisers. Reservations and refunds will only be accepted up to four working days before the meeting. Refunds on fees over £10.00 only. An administration fee of 15% will be charged on refunds.

Editors Note: This newsletter conforms to the guidelines issued by Executive and Finance Committee on the production of College Newsletters. Accordingly, the views and statements expressed within it are those of the authors and may not represent College policy. All contributions should be submitted as Word or rtf files to sduncan@rcpsych.ac.uk