

## Helping patients tell their story: narratives of body, mind and soul

Andrew Powell

*A patient who was a devout Christian was admitted to hospital as an emergency. She tried to explain to the duty psychiatrist the importance of her belief in 'the Holy Ghost', only to hear it reported in the ward round the next day that she had been seeing ghosts.*

### Introduction

In this chapter, I aim to show that the narrative set in motion when a patient is seen by a psychiatrist is not only an account of an individual's life experience but also attuned to the expectations of the psychiatrist – more than either of them may be aware. This is especially relevant to soul narrative, which is often invested with profound personal meaning, yet can lead to confusion when not understood, or else likely to remain unvoiced if a patient senses that their spiritual beliefs and concerns are not given credence. I conclude by illustrating how the soul narrative, when encouraged, can bring real therapeutic benefits.

### The pre-eminence of medical diagnosis

In general medicine, taking a patient's history is followed by hands-on examination of the body, feeling for lumps and bumps, listening to the heart and lungs and testing for abnormalities of the nervous system, followed when needed by a battery of investigations. The unspoken contract between physician and patient enables doctors to divide their attention between relating to their patients as persons and yet examining their bodies with the detachment needed to identify pathology and arrive at an accurate diagnosis (in Greek, *dia* means 'stand apart', *gnosis* means 'discern').

The art of diagnosis has its roots in the ancient civilisations of Egypt, Greece and China. But the physician of our time is heir principally to a scientific method that began during the Renaissance with the study of human anatomy and which has brought extraordinary knowledge of how the body works. A correct diagnosis will generally indicate a disease that has recognisable pathology, a cause (aetiology), a natural history (it may progress or remit) and an outcome (prognosis). At best, getting the diagnosis right leads to a treatment that cures and if not to a cure, then at least to the relief of symptoms; failing that, quality of care management for chronic illness; and when the condition is terminal, for best-practice end-of-life care.

Making the diagnosis requires a relentless kind of questioning impressed on every medical student and never forgotten: Where is the pain? Is it a dull ache or stabbing? Does it radiate? Does anything bring it on, or relieve it? How about exercise, or eating, or lying down? This kind of enquiry rapidly becomes second nature to doctors, like being a journalist on the trail

of something suspicious and digging away until the whole picture emerges. The diagnostic narrative is relatively impersonal, focussing on the elucidation of symptoms and their causes. Yet general medicine has long had to take note of the body-mind connection. We know from psychosomatic medicine, psychoneuroimmunology and liaison psychiatry that in-depth enquiry into a patient's personal life, feelings, stresses and habits may be required. Indeed, some 20% of consultations in general practice present with somatoform disorders (De Waal, 2004). Common to all these consultations, however, is the straightforward aim of helping the patient back to physical health and well-being. If mind and body can be likened to car and driver, the driver is being questioned in order to help with getting the car back on the road.

Mental health science, too, has its roots in physical medicine. More than a century ago, abnormal states of mind secondary to nutritional diseases, syphilis, porphyria, hormonal disturbances and brain injury encouraged the search for physical causation. A minority of mental disorders are indeed secondary to organic pathology, as with endocrine disorders, neurodegenerative disease, or where there is a brain lesion. More recently neurodevelopmental deficits are implicated in a number of conditions, including autistic spectrum disorders and possibly schizophrenia. In the field of intellectual disability, genetic counselling and research are proving invaluable. All of these conditions highlight the importance of psychiatry as a branch of medicine and underline the value of the diagnostic narrative.

### **Descriptive psychopathology: a two-edged sword?**

Yet it behoves us to question the relevance of physical medicine to current psychiatric practice, for general psychiatrists rarely come across organic pathology. Curiously, the broad acceptance of psychiatry as a medical speciality owes most to Emil Kraepelin's historic classification of the functional psychoses into schizophrenia and manic-depression (bipolar disorder) at the end of the 19<sup>th</sup> century. Thereafter, it only remained for psychiatry to demonstrate the biology of mental disorder. Even so, to this day the aetiology of schizophrenia and bipolar disorder remains obscure. Neurochemical hypotheses having proved inconclusive, new hope is now being invested in brain studies in the search for definitive neuropathology.

The pressure is on, for while the combined prevalence of schizophrenia and bipolar disorder in the population remains constant at around 2%, there now appears to be an epidemic of mental illness, since some 25% of women and 12% of men will need treatment for depression in the course of a lifetime (Mental health Foundation n.d.). According to the World Health Organisation (n.d.) (WHO), mental disorder currently affects one in ten adults, accounting for over 12% of the global burden of disease and over 40% of the total burden of disability in Europe and the Americas.

Most of these disorders have no clear-cut aetiology and no consistent prognosis. The picture is often a complex interplay of constitutional, developmental and environmental factors coupled with situational stress. Yet the diagnostic narrative in psychiatry, whether using the framework of the *International Classification of Disease (ICD)* or the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, has been to attempt to define mental illness with the same objectivity and rigour as physical disorders. For the most part it has simply led to the categorisation of symptom clusters. Descriptive psychopathology usefully serves as the lingua franca among psychiatrists, but often has little to say about the cause (and outcome) of the

presenting problem. Yet DSM and ICD between them encompass and label just about every aspect of the human condition. The questionable introduction in 1980 of the category of ‘major depression’ in DSM-III was followed by 21 million prescriptions for fluoxetine (Prozac) being dispensed over the next ten years (Shorter, 2014) and currently the psychopharmaceutical industry makes annual profits of around 87 billion dollars (Williams, 2011), a powerful testament to the widespread appeal of the pharmaceutical narrative of mental disorder (Davies, 2013).

### **Life comes with a health warning**

The indelicate quip, ‘life is a sexually transmitted disease for which there is no treatment and which is uniformly fatal’, pinpoints the reality of human suffering, something discussed by psychiatrists less than it deserves, possibly because we live in a culture that prefers a pharmaceutical narrative rather than face up to the travails of humanity. How might we account for the soaring prevalence of mental disorder? Is the human race in decline? Is the world of materialism and consumerism eroding the core values that make life feel worthwhile (Powell, 2013)? Or, as Thomas Szasz suggested more than half a century ago (Szasz, 1960), are we looking at the demographic of a societal narrative that now habitually pathologises the human condition?

These are complex matters and hard-pressed clinicians are not much given to questioning the extent that psychiatry mirrors an all-pervading societal narrative. Nevertheless, most psychiatrists would agree that the continuum of distress extends from the pain of the human condition at the one end to severe (and often treatable) mental illness at the other. Yet a fundamental problem remains: much of psychiatry has been built on unsubstantiated premises for which no amount of classification can compensate.

### **Dynamic psychopathology: another two-edged sword?**

All great institutions have to bear the strain of internal dissent. Psychiatry is no exception, for a competing narrative to the biomedical model began more than a century ago with Sigmund Freud. Freud promised a new understanding of the human mind in which doctor and patient would join in the search for meaning that lay encoded in the symptom; the symbolic life of the unconscious would be laid bare and its arcane mysteries revealed. For the first half of the 20<sup>th</sup> century, the narrative of psychoanalysis, known as ‘the talking cure’, reigned supreme in the Americas and Europe.

Central to this narrative is the notion that the therapist listens to and interprets the unconscious significance of the patient’s story. The understanding that follows relieves the patient of the symptom by revealing the source of emotions that have had to be repressed, denied or otherwise disavowed, as illustrated by the following example:

*Jean came into therapy with a history of recurrent panic attacks. The attacks intensified each time she entered a serious relationship that might lead to an emotional commitment, yet she very much wanted to settle down and have a family. In therapy Jean suffered a severe panic attack during a session just before the summer break. With the help of the therapist, Jean was able to explore the significance of this panic, which brought back painful memories of childhood when her mother had to be hospitalized for*

*a lengthy period due to a life-threatening illness. Once Jean understood that her panics were a resurgence of her fear of abandonment, the break could be successfully managed without further attacks. Three years after the conclusion of therapy, Jean wrote to let her therapist know she was now married and mother of a baby girl.*

Countless people have benefited from such an approach. However, the outcome is not always successful and there has been ethical concern over the imbalance of power that arises. For instance, how can a patient give truly informed consent when the analysis of 'unconscious' material is the prerogative of the therapist? How free is the patient to disagree with the therapist when this can be interpreted as 'resistance'? What about the risk that the patient's narrative is being subtly appropriated by the therapist and re-fashioned according to the therapist's world view? Seeing all of the human condition through the lens of dynamic psychopathology can result in therapy that is more a way of life than a treatment. Freud himself warned against this danger (Freud, 1937).

Good therapists go to great lengths to avoid the abuse of power. Yet when a professional accredited with expertise advises someone in need of help and who is less knowledgeable, the risk is always there, whether it be psychotherapy or pharmacotherapy. The more susceptible the patient, the greater the ethical obligation on the professional. Offering no conceptual map risks leaving the patient floundering, yet a favoured theoretical preconception can trammel a vulnerable mind.

If democracy of spirit is to prevail in the course of a psychological therapy, the therapist must take care not to make conjecture sound like fact (since no one can truly know what is in the mind of another) but rather to invite the patient to respond freely and authentically. No matter how appealing and persuasive a theory may be, authenticity holds the key to genuinely therapeutic narrative. This has to be the touchstone if one's patient is going to find, in the telling, a new, creative and enduring meaning to their story.

### **Authentic narrative**

In an authentic exchange, the narrative is an act of co-creation. Authenticity requires that both people meet on the basis of equality as human beings, each contributing with their own experience. Therapeutic expertise is able to be valued and acknowledged but it is important to recognise that 'therapist' and 'patient' are no more than complementary roles set up to enable the one to give to the other a special kind of assistance.

Across healthcare, the setting is conducive to a parent/child dynamic because of the knowingness of the clinician and the dependency needs of the patient. In some circumstances this is helpful, but there is the danger of precluding a more valid interpersonal exchange – validity founded on acknowledging that we all are travellers on life's journey, facing the same landmarks, losses, hopes and fears. As Carl Rogers remarked, 'what is most personal is most general' (Rogers, 1961: p.27); without this awareness no person, however clever and knowledgeable, could reach out and help another.

Especially in mental healthcare, when this authority-based dynamic stands in the way of authenticity, the balance needs restoring; then comes the discovery that each person is writing their own life story and that nobody can be the instrument for change except oneself.

The narrative that charts a person's life from birth through to this present moment must sooner or later find reconciliation with the past, for there is no changing the facts of the story, as the 10<sup>th</sup> century Persian poet and philosopher Omar Khayyám wryly reflects (Fitzgerald, 1895):

*'The Moving Finger writes; and, having writ,  
Moves on: nor all thy Piety nor Wit  
Shall lure it back to cancel half a Line,  
Nor all thy Tears wash out a Word of it.'*

What a person *can* change, however, is *how* to relate to those events of the past; whether to remain a victim of circumstance or to see adversity as the grit that makes the pearl. The choice lies between repeating the same chapter over and over or starting a new one. Every story must have its past; the life-affirming story has a future too. When the ego, through force of habit, resists change, the clinician can invite a more soulful exchange to lend support, as will be described later.

### **The power of narrative for good or ill**

A sign of mental health is that each person's chronicle of events and experiences is interwoven to form a coherent and meaningful narrative; 'living' this narrative is an act of involuntary creativity that enriches the self and its circle of intimates. Some people reach a wider audience through the arts, education, business or politics. Not least, the great spiritual exemplars have touched innumerable lives with their uncompromising narratives of wisdom and truth. Of the spiritual teacher, the Zen scholar Daisetz Suzuki writes:

*'His hands and feet are the brushes and the whole universe is the canvas on which he depicts his life... this picture is called history'* (Herrigel, 1953 p.8).

In contrast, psychotic narrative, while often vociferously proclaiming the 'truth', is likely to be painfully disjointed, or else tragically concrete as in the case of this patient with schizophrenia convicted of homicide, who said:

*'I took a life because I needed one'* (Cox, 1982)

Groups, too, can spawn 'psychotic' narratives in which the individual is swept up by perverse ideology, resulting in horrific genocide as in Rwanda (Ilibagiza, 2006), or mass suicide as in the case of the Jonestown massacre (Scheeres, 2011), when Jim Jones, the paranoid cult leader, commanded some 900 followers to take poison to save them from the evils of the world.

On the other hand, surrender of the self to a higher power is a hallmark of religious belief. Speaking in tongues (the 'Toronto blessing') is endorsed by many evangelical Christians as a divine gift. Should such altered states of consciousness be regarded as psychopathological? Not necessarily, according to ICD-10 which under trance and possession disorder (F44.3) specifies:

*'...Include here only trance states that are involuntary or unwanted, occurring outside religious or culturally accepted situations'* (World Health Organization, 2016).

In this case, psychiatry must distinguish between mental illness and mental health solely on the context of the event. Here we find a conflation of medical and social narratives that while offering some practical help does little to clarify what is really going on.

What, then, about people who join 'hearing voices' groups, in which many group members will have already been diagnosed as having mental illness? With the help of the group, a new kind of coherent narrative is established, based on sharing the experience of intrusive voices and how to challenge them and find a way to live with them. This may require strategies such as negotiating with the voices and insisting they wait until, say, the evening when they can be promised an hour of undivided attention (Romme & Escher, 1989).

Such narrative has moved away from the concept of psychopathology to becoming a means of adaptation. We might compare this with an amputee who, once the injury has been attended to, no longer regards himself as ill just because he will need a prosthesis.

These various narratives illustrate that 'psychopathology' is context bound and cannot be divorced from circumstance. When a person is deprived under the Mental Health Act of their right to freedom, the narrative is likely to be one of confusion, fear and anger and it may be impossible to engage in meaningful dialogue. The psychiatrist needs to tolerate the anger often shown by the patient, while remaining 'present' to help make sense of the anguish and confusion as it passes. As Professor Larry Davidson from Yale University, USA, says,

'Recovery means learning how to live outside the mental illness rather than inside it. To live inside the mental illness is to be lost in its downward spiral. Living outside schizophrenia is about reclaiming your life. It is about self-determination, choice, hope, and empowerment' (Summerville, 2009).

The construction of such a narrative of recovery is a powerful building tool in learning to live 'outside' the illness.

### **The spiritual narrative**

Psychiatrists face a unique challenge when evaluating experiences phenomenologically indistinguishable from mental illness, yet potentially invested with spiritual significance (Lucas, 2011). What distinguishes a person who has an acute and transient psychotic disorder, from one who has what turns out to be a life-changing spiritual revelation? Consider this hallucinatory episode:

*...Now as [Saul] was going along and approaching Damascus, suddenly a light from heaven flashed around him. He fell to the ground and heard a voice saying to him, "Saul, Saul, why do you persecute me?" He asked, "Who are you, Lord?" The reply came, "I am Jesus, whom you are persecuting" [...] Saul got up from the ground, and though his eyes were open, he could see nothing; so they led him by the hand and brought him into Damascus. For three days he was without sight, and neither ate nor drank.*

*Now there was a disciple in Damascus named Ananias [...] He laid his hands on Saul and said, "Brother Saul, the Lord Jesus, who appeared to you on your way here, has sent me so that you may regain your sight and be filled with the Holy Spirit." And immediately something like scales fell from his eyes, and his sight was restored' (Acts 9: 4, 5, 8-10, 17, 18, The Holy Bible, New Revised Standard Version).*

Would Saul (later renamed Paul the apostle), had he lived today, been diagnosed with acute and transient psychotic disorder? And what should we make of the risk of recurrence? Whereas many people who suffer repeated episodes of acute and transient psychotic disorder never progress to chronic schizophrenia (Farooq, 2012), one in eight does so within 5 years (Queirazza *et al*, 2014). Psychiatry has traditionally looked askance at spiritual and religious preoccupation because of this association with psychosis. Yet the researches of Koenig *et al* (2012) have demonstrated a broadly positive correlation between religion, spiritual practice, and improved mental as well as physical health. Given that many people have such 'exceptional human experiences', leading them to a new sense of meaning and purpose in life, perhaps we should not too readily focus on psychopathology for fear that illness may lie ahead.

There continues to be controversy nonetheless. A recent study by King *et al* (2013) claims to show that religion confers no additional protection against mental disorder when compared with those people who are neither spiritual nor religious. King also unequivocally states that 'people who have a spiritual understanding of life in the absence of a religious framework are vulnerable to mental disorder'. While King does not go so far as to suggest that 'spirituality' causes mental disorder, it would be easy to draw that erroneous conclusion. There is, however, an important sociological perspective to consider. Contemporary Western society, with its erosion of deeper values and the materialistic pursuit of pleasure, avoids asking the difficult questions 'Why are we here?' and 'What it is all for?' If a person is deeply preoccupied with such existential concerns, they may well be labelled as depressed. Yet self-doubt and anguish have always been features of the spiritual life, as instanced by such historic persons as Julian of Norwich and John of the Cross. In the largely secular society of Britain today, there is a burgeoning demographic of 'spiritual but not religious' for whom soul-searching can be a lonely pursuit. Without a climate of understanding or the community support of a faith tradition, the individual seeker may well struggle. Pargament (2011) points out that spiritual struggles have the potential for either good or bad mental health outcomes. So, 'Perhaps the question to ask is whether the world in which we now live is conducive to a good outcome' (Cook & Powell, 2013).

A more radical interpretation has been suggested by Razzaque, who turns Kings' conclusion upside down by suggesting that the finding is unremarkable, since people who have a mental disorder are more likely than others to be seeking a spiritual understanding of life. He writes: 'There is something at the core of the experience of mental illness that draws sufferers towards the spiritual. Their suffering is an echo of the suffering we all contain within us' (Razzaque, 2014: p.5).

This issue comes to the fore when we consider how to respond to a person who is in need of psychiatric help and in the throes of a spiritual crisis, be it loss of faith or an experience of overwhelming spiritual significance. Mental health services provide little by way of spiritually informed care. Consequently there is no way of knowing how often a transient psychotic episode might otherwise have become the turning point on a new path of meaning and purpose had the narrative only been explored in a different way.

This is a difficult area, especially as psychiatrists have a medically sanctioned role to relieve symptoms. It is neither their job to proselytise, nor to presume the role of spiritual advisor. Even so, by routinely taking a short spiritual history (Eagger, 2009), serious misunderstandings can be avoided. The Royal College of Psychiatrists has now affirmed that 'a tactful and

sensitive exploration of patients' religious beliefs and spirituality should routinely be considered and will sometimes be an essential component of clinical assessment' (Cook, 2013).

The discussion that takes place between patient and psychiatrist is potentially one of the most intimate the patient will ever have. Yet the more the narrative adheres to the medical diagnostic approach, the less will the dialogue engage with real existential concerns. Rather than dive too deep, many psychiatrists argue that what appear to be tangled preoccupations with the self, the world and even the cosmos fade away on recovery, suggesting that the perplexity and ruminations were secondary to mental disorder – and therefore best left well alone.

At the same time, psychiatrists know that conflict, loss and soul-searching are implicated in most mental breakdowns. Body, mind and soul, whose interweaving remains the greatest conundrum in psychiatry, have to be taken together if the psychiatrist is to help the patient recover from breakdown to wholeness of being.

### **Where the narratives of science and spirituality meet**

Classical science regards consciousness and its spiritual *essentia* (the soul) as epiphenomena, arising (somehow) from the physico-chemical processes of the brain. This approach, derived from Newtonian mechanics<sup>1</sup> treats the mind and its contents purely as emergent psychological phenomena (God included).

Such a physicalist approach is founded on study (and measurement) of the object. Because consciousness is experienced subjectively, it has therefore to be ruled out of court. Yet one thing everyone agrees on is that they are conscious! It seems that degrees of consciousness are present in all life forms, most probably in proportion to the complexity of neural structure. A cat or dog, for instance, has awareness similar to our own. But we humans have further evolved the capacity to be self-aware which, coupled with language, enables inner dialogue, personal history and identity, and freedom of choice.

The time-honoured metaphysical view, of which natural science has always been so intolerant, is now being reframed by the 'new' science of quantum field theory, which seeks to understand the experimentally proven non-local properties of consciousness (Hameroff & Chopra, 2012). This perspective regards consciousness as pre-existent and pre-eminent; the brain as the on-board computer taps into a ubiquitous field of consciousness rather like a television picking up a broadcast signal and integrates it with the memory store of each person's experiences. The result: a unique and personal self-aware narrative.

The implications of these two perspectives are very different. The 'bottom-up' physicalist view sees each human being as a discrete entity, having an inner world comprised only of personal experience and communicating with others solely by means of the special sense organs. On this basis, rationalists argue that God is nothing but a mental projection, good for warding off the (ego's) fear of oblivion and death.

---

<sup>1</sup> Isaac Newton was deeply religious and saw no contradiction between his laws of physics and a creator God. He wrote, 'the motions which the planets now have could not spring from any natural cause alone, but were impressed by an intelligent Agent [...] not blind and fortuitous, but very well skilled in Mechanicks and Geometry' (Heller, 2009: p.148).

The 'top-down' metaphysical view, on the other hand, sees every human being as participating in a shared consciousness that ultimately extends beyond the self, indeed beyond the bounds of individual birth and death. This approach is consonant with the proposition first made by Aristotle in *Metaphysics* that the whole is more than the sum of its parts; it opens the way to a fundamental figure/ground reversal so that 'God', far from being a mere projection, is the *materium primum* of all that is.

Must we choose either one or other narrative? Surely there is room for both, for the greater does not exclude the lesser. The physicist Thomas Campbell reminds us that the subsystem, in this case human intelligence, can never fully comprehend the system of which it is a part - what he calls the larger consciousness system (Campbell, 2007). Campbell uses the impartial language of physics when speaking of the data stream that conjoins part and whole. Yet in the subjective language of spirituality we find the same mystery in the powerful recognition that 'I belong to more than myself'.

The various faith traditions each frame this mystery in their own way. For example, while Islam deliberately refrains from representational images of Allah, the Judeo-Christian faiths envision God according to an archetypal Imago Dei. Hinduism has something of both; Brahman the supreme power cannot be described but manifests through a multitude of lesser deities. Buddhists eschew a personal God altogether. The burgeoning 'spiritual but not religious' demographic is more likely to speak of a unitive and all-embracing 'higher power' or 'ultimate truth'.

### **Narratives of the soul**

What, then, of the soul - a word notably absent from the vocabulary of psychiatry and strangely perhaps, given that *psyche* in Greek means soul? The soul does not have to imply transcendence; some will refer simply to what is best in humanity - compassion, wisdom, unconditional love and innate goodness. In this sense, everyone can be said to have a soul. Others will regard the soul as the expression of the divine in the human form - that we are souls and that this is the source of our capacity for love and our awareness of goodness, beauty and truth. To borrow from Teilhard de Chardin (2008), the difference in perspective is whether we see ourselves as human beings on a spiritual journey or spiritual beings on a human journey.

Either way, the human soul escapes any narrow definition and yet it holds a sacred meaning for all creeds and cultures. As Carl Jung pointed out, the soul is an archetype with profound symbolism second only to the supreme archetype of the Imago Dei (Jung, 1951).

From the standpoint of enabling patients to come from the deepest place within, psychiatrists need to accept that words such as 'God' and 'soul' are for some people instinctive and necessary when questioning the meaning and purpose of human existence, and what may lie beyond the physical bounds of birth and death. The psychiatrist simply needs to stay open-minded and be genuinely interested in where the narrative leads.

The psychiatric assessment, not least the mental state examination, is necessarily systematic, structured and formal to a degree. Even so, once the patient's welfare and safety is assured and the necessary treatment measures are put in place, there is the opportunity for a different kind of heartfelt narrative to unfold. For the psychiatrist, this entails suspending judgement and engaging compassionately with one's patient as a fellow human being. It

means being willing to ‘accompany’ the patient in searching for answers to the big questions of life and death, including the nature and purpose of the soul, while trusting that the mental health crisis, however painful, can lead to an enrichment of life and its values, sometimes with new and very different life goals (Powell, 2009).

Much of this is what good counselling and psychotherapy offers – empathy, warmth and genuineness, as researched nearly 50 years ago by Truax & Carkhuff (1967). But here the psychiatrist ventures further. Spirituality has two dimensions: the quest for answers to the ultimate meaning and purpose of life, and the experience of wholeness of being that can bring inner strength and peace. By supporting a soulful narrative, the psychiatrist helps those profound questions to be asked perhaps for the first time (Spirituality and Psychiatry Special Interest Group, 2014). Then, as with the proverb of the person who is searching everywhere until they realise the necklace is already around their neck, the patient who begins to find their own answers to those deep questions discovers a wisdom they never knew they had and one that can help bring peace of mind.

Such conversations are, in fact, conversations ‘soul-to-soul’. Whatever arises will happen naturally and exactly as it should when the psychiatrist is able to be fully ‘present’ and concerned only to help the patient find his or her ‘truth’.

The soul narrative can often be elicited with a few simple prompts. Sometimes it helps simply to amplify what a patient has begun to say, or to encourage a person to think the ‘unthinkable’. For instance, if someone is contemplating suicide, it is worth finding out if they believe death is the absolute and final end. If the patient is unsure (as many are), it makes sense to ask ‘if there were to be an existence or a world beyond, how would you imagine it to be?’ Encouragement to step outside the life being lived can bring a different perspective to bear, one that is wiser, more forgiving and compassionate than the harsh self-judgement that so often accompanies mental anguish, as the following example shows:

*A young man burdened with a deep sense of failure and unable to see any future found himself in fear and trembling before God. Invited to ‘listen’ to what God might say to him, to his surprise he found himself being gently admonished, then lovingly told to continue with his life and to remember that success is not measured by wealth or fame but by finding love for his friends, his family and himself.*

In cases of traumatic bereavement, the psychiatrist can ask about things left unresolved or unsaid that might be important to address. Often the patient will begin by saying it is too late. Instead, they can be invited to close their eyes, form a picture of the loved one and speak to them as if they were right there in the room. Not only can what was unexpressed now be voiced, but a narrative of healing can begin. By guiding the person into a conversation, e.g. ‘What do you need to ask/tell the person?’ followed by ‘Now listen to what they need to say to you,’ the soul can make itself heard, as shown in this example:

*A middle-aged woman had cared for her ageing father during his final illness and decline. Although close, their relationship had often been a tense one, and as he became more infirm and fought his disability, she often felt he was fighting her too. At times she got frustrated and angry, and then guilty for having such feelings. After her father passed away, she became depressed, reproaching herself for not ‘having done better’. Assisted by the psychiatrist, she was able to ‘meet’ her father. She was encouraged to tell him about feeling how she had let him down. To her surprise, the answer came back that he was deeply grateful for the help and support she had given. He ‘said’ to her, ‘I*

*know you did your very best. I am grateful, I love you and I want you to be happy'. The daughter and father could now part with a loving farewell.*

Often problems that might seem insoluble can be approached by 'going within' and listening to the soul directly:

*A man brought up alone by an abusive alcoholic mother was suffering from chronic depression, heavily laced with anger towards his mother. He could see that bitterness was spoiling his life but could only bring himself to say 'I'll never forgive what she did to me'. The therapist asked him if he wished that he could forgive. He replied, 'more than anything but it's impossible'. The psychiatrist now knew that although the egoic mind would not relent, the soul's capacity for forgiveness was present, so she invited him to 'go within' and find out what his heart would say if it could only speak<sup>2</sup>. His heart said to him, 'I am in such pain. All this anger is hurting me. Please stop before I break. I'm here to bring love into your life. Don't turn your back on me'. The patient fell silent for a while, sighed and then said, to himself as much as the psychiatrist, 'It's time I stopped hating and started loving. I want to get a life while there's time.'*

## **In conclusion**

I have set out to show how, across a wide range of clinical objectives, paying attention to narrative is important both for diagnosis and for treatment. Starting with the physical, I describe how narrative changes when engaging with the mental, and how making sense of the patient's story becomes a co-creation of doctor and patient. Lastly, I explore how narrative changes yet again when the focus moves to the spiritual.

This further shift is a profound one, for the narrative of the soul knows no bounds. Transcending the limitations of the mundane life, soul wisdom brings a deeper understanding to the human predicament. When the psychiatrist is willing to be fully 'present', and able to offer a genuine and heartfelt connection with the individual who is in pain, the way is opened to reconciliation, forgiveness and peace of mind. The key lies in this: though the ego may be deeply aggrieved, the soul always seeks to love. The psychiatrist who can reach out to the soul in their patient is privileged to share in a narrative that brings healing to the psyche and fresh hope to the dispirited.

## **References**

Campbell, T. (2007) *My Big Toe: A Trilogy Unifying Philosophy, Physics, and Metaphysics: Awakening, Discovery, Inner Workings*. Lightning Strike Books.

Cook, C.C.H. (2013) *Recommendations for psychiatrists on spirituality and religion* (Position Statement PS03/2013). Royal College of Psychiatrists.

Cook, C.C.H. & Powell, A. (2013) Spirituality is not bad for our mental health. *British Journal of Psychiatry* **202**, 385-6.

---

<sup>2</sup> *Le cœur a ses raisons, que la raison ne connaît point* [The heart has its reasons, which reason does not know]. (Pascal, 1660)

- Cox, M. (1982) 'I took a life because I needed one': psychotherapeutic possibilities with the schizophrenic offender-patient.' *Psychotherapy and Psychosomatics*, **37**, 96–105.
- Davies, J. (2013) *Cracked: Why Psychiatry is Doing More Harm Than Good*. Icon Books.
- De Waal, M., Arnold, I., Eekhof, J., *et al* (2004) Somatoform disorders in general practice: prevalence, functional impairment and comorbidity with anxiety and depressive disorders. *British Journal of Psychiatry* **184**, 470-476.
- Egger, S. (2009) A guide to the assessment of spiritual concerns in mental healthcare. Royal College of Psychiatrists. Available at [http://www.rcpsych.ac.uk/pdf/A\\_guide\\_to\\_the\\_assessment\\_of\\_spiritual\\_concerns\\_in\\_mental\\_healthcare.pdf](http://www.rcpsych.ac.uk/pdf/A_guide_to_the_assessment_of_spiritual_concerns_in_mental_healthcare.pdf) (accessed 5 November 2015).
- Farooq, S. (2012) Is acute and transient psychotic disorder (ATPD) mini schizophrenia? The evidence from phenomenology and epidemiology. *Psychiatria Danubina* **24** (suppl. 3), 311–315.
- Fitzgerald, E. (1859) (Transl.) *The Rubáiyát of Omar Khayyám*. Collins 1989.
- Freud, S. (1937) Analysis terminable and interminable. In *The Standard Edition of the Complete Psychological Works of Sigmund Freud*. Volume 23. Hogarth Press, 1968.
- Hameroff, S. & Chopra, D. (2012) The 'Quantum Soul.' In *Exploring Frontiers of the Mind-Brain Relationship* (eds A. Moreira-Almeida, F. Santana Santos). Springer.
- Heller, M. (2009) *Ultimate Explanations of the Universe*. Springer.
- Herrigel, E. (1953) *Zen in the Art of Archery*. Routledge and Kegan Paul.
- Ilibagiza, I. (2006) *Left To Tell*. Hay House.
- Jung, C. (1951) Researches into the phenomenology of the self. In *Collected Works*. Vol. 9, Part 2: Aion. Routledge and Kegan Paul.
- King, M., Marston, L., McManus, S., *et al* (2013) Religion, spirituality and mental health: results from a national study of English households. *British Journal of Psychiatry*, **202**, 68–73.
- Koenig, H.G., King, D.E. & Carson, V.B. (2012) *Handbook of Religion and Health*, 2<sup>nd</sup> edn. Oxford University Press.
- Lucas, C. (2011) *In Case Of Spiritual Emergency*. Findhorn Press.
- Mental Health Foundation (n.d.) Mental Health Statistics. Available at <http://www.mentalhealth.org.uk/help-information/mental-health-statistics/> (accessed 5 November 2015).
- Pargament, K.I. (2011) *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred*. Guilford Press.
- Pascal, B. (1660) *Pensees*. Transl. W.F.Trotter: Section IV: 'Of the Means of Belief': p.227. Reprinted: 2005. Digireads.com.
- Powell, A. (2009) Soul-centred psychotherapy. Available at <http://www.rcpsych.ac.uk/college/specialinterestgroups/spirituality/publications.aspx#p> (accessed 5 November 2015).

- Powell, A. (2013) Modernity and the beleaguered soul. Available at <http://www.rcpsych.ac.uk/college/specialinterestgroups/spirituality/publications.aspx#p> (accessed 5 November 2015).
- Queirazza, F., Semple, D.M. & Lawrie, S.M. (2014) Transition to schizophrenia in acute and transient psychotic disorders. *British Journal of Psychiatry*. **204**, 299 – 305.
- Razzaque, R. (2014) *Breaking Down is Waking Up*. Watkins Publishing.
- Rogers, C. (1961) *On Becoming a Person: A Therapist's View of Psychotherapy*. Houghton Mifflin
- Romme, M. & Escher, A. (1989) Hearing Voices. *Schizophrenia Bulletin*. **15**, 209-216.
- Scheeres, J. (2011) *A Thousand Lives: The Untold Story of Jonestown*. Simon & Schuster.
- Shorter, E. (2014) The 25<sup>th</sup> anniversary of the launch of Prozac gives pause for thought: where did we go wrong? *British Journal of Psychiatry*. **204**, 331-332.
- Spirituality and Psychiatry Special Interest Group (2014) Spirituality and Mental Health ('Mental Health Information' leaflet). Royal College of Psychiatrists. Available at <http://www.rcpsych.ac.uk/mentalhealthinformation/therapies/spiritualityandmentalhealth.aspx> (accessed 5 November 2015).
- Summerville, C. (2009) Your Recovery Journey. Available at <http://www.your-recovery-journey.ca/Message.htm> (accessed 5 November 2015).
- Szasz, T. (1960) The myth of mental illness. *American Psychologist*. **15**, 113-118.
- Teilhard de Chardin, P. (2008) *The Phenomenon of Man*. Harper Perennial.
- Truax, C.B. & Carkhuff, R.R. (1967) *Towards Effective Counseling and Psychotherapy*. Aldine.
- Williams, R. (2011) How the drug companies are controlling our lives. *Psychology Today*, 13 May. Available at <http://www.psychologytoday.com/blog/wired-success/201105/how-the-drug-companies-are-controlling-our-lives-part-1> (accessed 5 November 2015).
- World Health Organization (n.d.) Global burden of disease. Available at [http://www.who.int/healthinfo/global\\_burden\\_disease/en/](http://www.who.int/healthinfo/global_burden_disease/en/) (accessed 5 November 2015).
- World Health Organization (2016) *International Statistical Classification of Diseases and Related Health Problems, 10<sup>th</sup> Revision (ICD-10)*. Version: 2016. WHO. Available at <http://apps.who.int/classifications/icd10/browse/2016/en> (accessed 27 January 2016).

This chapter has been reproduced by kind permission of the Royal College of Psychiatrists from [\*Spirituality and Narrative in Psychiatric Practice\*](#) editors Christopher C.H. Cook, Andrew Powell and Andrew Sims, RCPsych Publications 2016.

© The Royal College of Psychiatrists 2016