'Recovery and well-being: the search for the soul'

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Abstract

Mental well-being is nourished by the capacity for love. Yet we cannot love others, or love life, unless we experience love within the self, and love for ourselves. But then we need also to ask what kind of self this is.

We are most familiar with the everyday, mundane self that is the home of the ego, indispensable for our survival in a social world of competition, consumerism and personal ambition. There is a price to pay: the constant threat of failure, humiliation and loss can lead to overwhelming stress, resulting in breakdown.

All human beings have, without exception, a deeper self that is the foundation of our humanity and our spiritual birthright. This is the soul. It doesn't need love, for its nature is love, expressed in unity, harmony and the desire for wholeness of being. If the ego is like an errant child, then this is the unconditional love of the parent.

Wholeness comes about when we feel both inwardly and outwardly connected; conscious that every one of us is unique and special, and yet that what is most personal is most universal. From that place of wholeness we can appreciate that what matters is not success in the eyes of the world but to be able to live with an open heart.

Rather than relying on social norms as a measure of recovery from breakdown, it is important to explore how a person may align themselves with this deeper self. The mental health professional can be crucial in encouraging those who have suffered breakdown to gain the confidence to live 'soulfully', albeit in a largely ego-driven and intolerant society, by validating and affirming the new journey that has begun.

What is mental illness?

I would venture to say that for the most part, we still don't really know. We are deluged with operational definitions, some of which derive from pragmatic findings, some arising from theories of human development and others from response to specific treatments. A minority are rooted in neuroscience - although extrapolating from brain to mind continues to be fraught with difficulty. Psychiatry, being occupied with normative values, also casts its diagnostic net over the more eccentric aspects of human thought and conduct that are to be found way out on the extremes of the mean distribution curve. Consequently, despite best efforts to remain scientific and impartial, psychiatry gets drawn into making moral judgments that have all kinds of treatment implications. The diagnosis of personality disorder may reassure by categorising and medicalising deviant human behaviour, but for the most part it takes us down a therapeutic blind alley.

This is not intended to sound like an anti-psychiatry diatribe. Being a competent and caring psychiatrist is probably one of the hardest jobs around and I know many who are doing their level best to help their fellow human beings find relief from unbearable suffering of one kind or another. Most volunteered for the role because they are deeply interested in human nature and genuinely wish to be of service.

Emboldened by the twin frontiers of research in the 20th century, first psychoanalysis and then pharmacotherapy, my generation of psychiatrists trained in the 70's was optimistic that both the severely mentally ill and what we then called the neuroses would yield to either one or both approaches. Since that time, there has been a proliferation of psychological treatments, and neuroscience has begun to map brain function in ways that were unimaginable twenty years ago. Research continues apace into the genetic predisposition to mental illness, along with a whole host of other factors, from covert neuro-developmental abnormalities; to infections early in life; to the physiological sequelae on the brain of emotional trauma, as well as biochemical triggers, environmental or self-inflicted as with substance misuse – the list is long and ever-lengthening.

There is a minority of academic psychiatrists who read in detail the papers published in the British Journal of Psychiatry along with the mandatory statistics that accompany them. Yet most psychiatrists I know would admit to scanning the articles for any headline results that could influence the way one deals with a clinical problem that may turn up in next week's outpatient clinic, and not to look much further than that. The sacred cow of a robust evidence base drawn from epidemiological studies and large-scale outcome research does not always help when one is faced with a person who is uniquely individual, and on whom stresses are impacting in a unique way.

Year on year, the database continues to expand at bewildering speed, yet less and less of it seems to relate in any direct or immediate way to the psychiatric consultation. As the saying goes, we know more and more about the car but where is the driver? We have also learned that pharmaceutical breakthroughs often turn out to create problems as fast as they alleviate them, as for instance with the prescribing of benzodiazepines. The enthusiasm that greeted the new wave of second generation (atypical) antipsychotic drugs has now been tempered by recognition of their limitations and side-effects. The history of anti-depressants tells the same story. In the 60's, monoamine oxidase inhibitors, the MAOI's, succeeded tricyclics as new wonder drugs until hypertensive crises and the dietary regime proved a major drawback. Another surge of enthusiasm heralded the arrival of the selective serotonin reuptake inhibitors, the SSRIs, in the 90's. Now the side effects of SSRIs, some of them serious, including the effects on the developing foetus, are increasingly of concern.

Nevertheless, there is a handful of tried and tested drugs which every psychiatrist knows are worth trying. A drug may or may not work for any one individual and often a therapeutic trial is the best bet. The jury is out on whether these drugs have any kind of curative effect or whether they essentially provide symptom relief until Nature, life, call it what you will, enables recovery to take place. 'Wait and see' is the rule for much of psychiatry.

The burden of disability in mental healthcare is enormous. There is the enduring incidence of schizophrenia and bipolar disorder, each with a world-wide prevalence of around 1%. Although the core pathology isn't understood in either case, psychiatrists generally believe that they are dealing with brain disease comparable with other medical illnesses. Then there

is all the rest, a great hotchpotch of psychopathology, symptomatology, morbidity and complex presentations of personal, interpersonal and social dysfunction. In the first five years of Prozac coming on the market over 10 million prescriptions were issued. Around 25% of women and 12% of men will suffer major depression during their lifetime. (The young are not spared either - around one child in ten in the USA is now on medication for Attention Deficit Hyperactivity Disorder). Beyond the immediate ambit of psychiatry, over one third of people seriously medically ill have been shown to be clinically depressed.

According to the World Health Organisation, taken worldwide, one in ten adults is affected by mental disorder, accounting for over 12% of the global burden of disease and over 40% of the total burden of disability in Europe and the Americas.

The role of the psychiatrist

I have underlined these facts to show that such a pandemic will not be alleviated, let alone cured, by medication alone. But what does such prevalence signify? How much of it is the sheer culmination of misery that goes with the human condition, but not previously labelled with a diagnosis? How much more arises from the cultural changes of the last one hundred years in which material success and consumerism have become new gods at the cost of impoverishment of the inner life?

We know from both animal studies and clinical observation that stress can bring about changes in brain chemistry, some of it probably irreversible and leading to long term vulnerability. So we will never understand mental illness by looking at it in isolation; rather, we must look at the whole person and the life context. This brings me back to my metaphor of driver and car, not least the terrain through which the route must pass. And what of the destination? In a secular society geared to material achievements, ageing brings poor comfort, with little awaiting except the finality of death, probably in a care home somewhere and very likely suffering from Alzheimer's disease.

Human beings need to be in relationship with others from cradle to grave, a far cry from the picture of isolation and loneliness that we so often see today. Falling ill, whatever the diagnosis, only increases the need for human warmth and intimacy. So, to continue with my metaphor, is there anyone willing to sit alongside the driver? Isn't this what psychotherapists do? Unfortunately, mainstream psychological treatments are now mostly short term and focussed on symptom reduction rather than making a dependable human relationship. Where is the time and opportunity to explore with one's patient what kind of journey through life will meet his/her needs, hopes and values?

Finally, if I may stretch this well-worn metaphor to include the social perspective, there are rules of the road without which we would have traffic chaos. We get from A to B by means of a highly regulated code of conduct. Dangerous drivers get taken off the road for their own safety and that of others. Accordingly, psychiatrists are obliged to balance precariously between the roles of the physician and social policeman. There are profound ethical issues. What is our mandate to relieve suffering? Is someone determined on suicide necessarily ill and therefore a case for treatment, willingly or unwillingly? What is the meaning of risk? Living in a risk-averse society, does it follow that we should unhesitatingly subscribe to the

social norm? Are clinicians encouraged, and given the time, to reflect seriously on these matters, or does the work load, exacerbated by the ever-present threat of litigation, drive us to make decisions according to protocol rather than exploring in depth such concerns with our patients face-to-face?

Forty years ago, things seemed more straightforward. Even though the treatment might not work, at least we thought we knew what we were doing. After all, treatments don't always work in general medicine either. The psychiatric establishment brushed aside the radical challenge posed by R.D. Laing and others and busied itself with demonstrating that the treatment of mental illness could stand shoulder to shoulder with any other branch of medicine.

This optimism was harnessed by the politics of care in the community, which despite best intentions proved to be a very mixed blessing. At any rate, before long, the old-style medical model gave way to the bio-psycho-social model, which in turn opened the way for the MDT, the multi-disciplinary team.

Surely this would lead to more compassionate, rounded and person-centred provision of mental healthcare? I think that for some patients, it turned out to be not so. In the former world of the consultant psychiatrist who was indisputably in charge, patients were offered an illness model which relieved uncertainty, was delivered with conviction and left a person's inner life more or less untouched. A patient was 'under' Dr So-and-so, who maintained personal contact often for many years. Consultants knew their patients much like a good general practitioner and this immensely reassured some patients.

However laudable the bio-psycho-social model might be, the new-style MDT introduced a good deal of unintended confusion. The familiarity and informality with which a whole range of staff would meet and greet patients offered friendly support but with no guarantee that it would lead to any deeper understanding. Not least when being forcibly treated under the Mental Health Act, patients could feel themselves in a Kafka-like scenario. Who is in charge? How are decisions being made? Where is the doctor - indeed, is there a consultant?

As pressure on beds increased, in-patient units increasingly became places of containment for seriously ill patients. Gone was the notion of sanctuary, which for some had been a valued provision of care. The 'patient journey' as it was now called, came to be accompanied by a bewildering array of support agencies, but who among them would have the motivation and time to reach out and connect with the personhood of the patient?

From Pathology to Personhood

My own specialisation in psychotherapy at the Maudsley Hospital led me into the world of psychoanalysis. This ensured that I continued working at a deep level with my patients, which was a source of great personal satisfaction for me and a good number of my patients left happy that the problems they came with had been resolved. But as the years passed, I began to question the nature of the set-up with its arcane formality, the inscrutability of the therapist, the focus on unconscious defence, the disconnection from the body and the imbalance of power that constantly reinforces the perception of the therapist as a parental figure. I also observed that if the therapist hung on to the patient too long (for there is

always more work to be done) the patient could as easily get buried in their childhood as freed from it.

Analytical psychotherapy suits some therapists and some patients and I'm well aware that it helps in some circumstances. But if relating to personhood means seeing past the disability, whatever it may be, finding and encouraging the wholeness in that person, and affirming him/her as one's equal and an adult, then I have to say that psychoanalysis does not work like that.

My subsequent training as a group analyst took me into the more egalitarian society of the therapeutic group, where members of the group coming from very different backgrounds could share the richness of their life experience, support each other and yet powerfully challenge each other's assumptions and behaviours. As each group developed and matured, members learned to value and respect each other's personhood. Yet I must own that due to the archetypal constellation of the group as family, the day came when I felt I had been long enough in the role of a single parent raising large numbers of children. It was a pleasure seeing them all growing up and leaving home, but I decided that from now on the only parent I wished to be was the one for my own family.

I also trained in psychodrama, where I found the therapeutic democracy appealing and refreshing. It opened me to seeing my patients in a new light. In psychodrama, therapist and patient work as a team, the therapist (called director) helping guide the patient (known as the protagonist) through scenes from life being enacted for therapeutic purposes. Most are about crucial events in the past, but potential future scenes may be rehearsed too. Group members take on the roles of important others chosen by the protagonist when recreating the scene. The director never claims to know what is in the mind of the protagonist, or what should be worked on next, for the drama belongs to the protagonist, deeply committed as a whole person to facing unresolved pain and loss, choosing which scenes to work on, and extending to the self (more often than not one's own child-self) the love and understanding previously lacking. At certain moments, in order to stay with the body it is best not to use words. The director might say 'don't tell me, show me'. In a scene of painful loss, a person's need to be physically held and comforted can be met, sometimes breaking through a lifetime's isolation. The personhood of the therapist, too, is revealed in the sharing that follows the session, an expression of common humanity that helps break down isolation, build trust and restore hope.

Personhood and Recovery

It has been stated by Anthony (1993) that on-going symptoms do not stand in the way of recovery provided that the person experiences 'a way of living that is a satisfying, hopeful and contributing life, even with limitations caused by illness'. To this we might add a pithy observation by Professor Larry Davidson from Yale who 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). This is an important statement, one that we should not limit to schizophrenia, for it addresses the danger of becoming identified with the 'illness' - to live inside it – and to become trapped

and even defined by it. The more that mental health professionals focus on pathology, be it of the descriptive or dynamic varieties, the greater the risk of unwittingly reinforcing this identification.

What about 'living outside your illness'? There is universal applicability here, for illness casts its shadow on everyone sooner or later, bringing the realisation that pain and loss, whether physical or mental, goes with the actuality of life. The challenge that faces all of us is to take responsibility for living the best life we can that circumstances will allow. Indeed, taking responsibility for oneself and one's life is at the heart of personhood.

This issue is crucial in mental healthcare. Sometimes psychiatrists have to intervene and force a person along a path not chosen. It may be deemed necessary but it is a deep affront to personhood and understandably inculcates resistance and resentment. There is a world of difference between coercion and encouragement; where the former diminishes personhood, the latter affirms it. No psychiatrist can apologise too much for depriving a person of their freedom, regardless of the necessity for such action.

From Person to Soul

Working person to person in psychodrama brought home to me the awareness of how much we are all fellow travellers in life, sharing in the same challenges, struggles and growing pains that beset every human being. But I saw something else, too, which impressed me deeply – how it happened that when a person takes on the role of someone they perceive as wise (in the ultimate case no lesser a presence than God), they find themselves speaking from within that role with wisdom beyond their years and experience.

From the writings of Carl Jung I had come across the supreme archetype of the collective unconscious, the Self; how we humans are born with a deep and subtle knowledge of things greater than the small world that each one of us makes our own. I could see how psychodrama harnessed the power of this archetype to therapeutic ends.

This greater Self - some would say, Infinite Self - takes us beyond the mundane level of social habits, needs and desires to seek meaning and purpose in a larger framework that encompasses birth, life and death. This is not the 'ungrounded' kind of spirituality that leads to turning away from human society. It is on the contrary about embodying the wholeness that it is in each of us to express, both in relationship to self and towards others. To live whole-heartedly in this way is far more important than striving for the external trappings of success.

Coming from my professional background, I hesitated at first to use the word soul. But having by now ventured into the field of transpersonal psychology and learning first-hand about spiritual healing and the shamanic tradition, what else should I call this innate wisdom that goes beyond personhood, is unconcerned with the trials and tribulations of the ego and remains untouched by the storms of life?

Left to its devices, the mind deals with intractable problems by labelling them and then usually agonising about them. Unfortunately the mind can tell itself just about anything and

has very little sense of direction. Since we experience the world 'not as it is but as we are', we are liable to find ourselves being buffeted by storm force winds.

If, on the other hand, we seek out the soul, we may better discern the problem for what it is and where it is – not belonging to the outer world but to the turbulent inner world of the mind. For the soul, unencumbered by the emotional crises of the ego, calmly observes human life as if scenes from a play. It witnesses our every move as day by day we write the script, determinedly go about building the sets and props, play our parts with all due gravity, and then, only too often, mistake the play for being somebody else's creation!

From the perspective of emotional intelligence, the human race so far has not progressed much beyond the kindergarten. Under the sway of the ego, what it takes for love is usually need in disguise, and when needs are frustrated, hatred is kindled. Then we really start to suffer, and make others suffer too.

The kind of love the soul offers is not like this. It is love that arises from the awareness of one-ness, of seeing oneself in the other, knowing that the problem is never really 'out there' but 'in here', in the drama created by the mind. While emotions come and go like clouds, the soul is unwavering, and when personhood fragments under the impact of stress, the soul is on hand to help restore wholeness of being, bringing compassion and magnanimity of heart to the anguish of human life.

On a practical note, it is easy enough when taking the spiritual history to include asking about the soul and if this touches a chord, exploring how the soul might be felt or seen. Many will point to the heart. If there is some problem or dilemma that is not finding an answer, it can help to suggest closing one's eyes, going to that place within the self and directly experiencing just how good the calmness and kindness of the soul can feel; then, while staying in touch with the feeling, to take another look at the problem and see if there might be a different kind of solution, or way to respond.

Closing remarks

In this paper I have tried to show that although sadly neglected in the burden and heat of mental healthcare, the soul is alive and well. In addition, since we first need to know what to be looking out for or else we won't find it, I have taken the liberty of characterising the soul with a description which is, of course, entirely inadequate.

I have written elsewhere how soul awareness can be engaged in specific therapeutic approaches (Powell 2009/2011). But here I want to conclude by highlighting something else, which owes nothing to a particular method or technique, requires no psychotherapy training and is applicable to the whole field of mental healthcare, indeed, every human relationship! Yet it is frequently overlooked because it doesn't suit the ego to remember it.

'If you want to change the world, first change yourself', said Mahatma Ghandi. This precept reminds us that only by the example we set do we inspire others to do likewise. If we diagnose and treat our patients like case studies from a textbook, we may tick any amount of boxes but never meet the patient. If we can address specific mental health needs at the same time as meeting our patients' personhood with our own, we will not only get to know

the patient but affirm the person. If we go the extra mile and make the connection soul-to-soul, we facilitate a depth of understanding and a breadth of vision that transcends the wounds of the ego. To borrow from the serenity prayer[1], we and our patients are helped to find the serenity to accept the things we cannot change, courage to change the things we can, and wisdom to know the difference.

Because the soul doesn't pass judgement, our patients do not feel judged. Because the soul is compassionate, our patients are helped to forgive themselves and others. And because the soul knows only love, our patients are helped to heal.

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[1] 'God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference'. Reinhold Niebuhr.