‘Spirituality and psychiatry – crossing the divide’

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Introduction

I would like to explain how I came to be involved in the field of mental health and spirituality. I want to do this not because I think there is anything so special about my case but because it may encourage others in the healthcare professions to feel they can do the same. Although prejudice is still encountered in certain quarters, in recent years there has been an appreciable shift of opinion, enough to ensure that health professionals who declare their interest in the spiritual dimension will find themselves in good company.

Medicine as science of the body

After qualifying as a doctor in 1969, but before specialising in psychiatry, I worked for two years in acute hospital medicine. The experience lives vividly with me to this day. The technology of coronary care had just arrived, along with a whole raft of advances in the investigation and treatment of a wide range of disease. The medical model was highly mechanistic, as it continues to this day.

Following a paper chase of clues leading to a treatment that is specific and effective offers a great deal of intellectual satisfaction for the doctor, as well as the pleasure of seeing one’s patient get better. I will confess that I was rather less taken with the task of supporting patients with chronic conditions, unlikely to recover and at best being maintained in status quo. There seemed to be less ‘to do’, and no one helped young doctors understand the art of ‘being with’.

In those days, medical students learned to dissect dead bodies long before they were ever allowed to touch live patients. Later, when doing our obstetrics, we helped deliver babies under the watchful eye of the midwife. Even so, the miracle of birth took second place to the need to examine the baby, check for genetic abnormalities, listen to the heart and so on. I remember a few years later trying to resuscitate a baby in casualty. It was a cot death and there was nothing we were able to do. I had to tell the mother. She was inconsolable, of course, and I felt wretched too. I couldn’t think of what to say. Death, whether in the young or old, was invariably the great enemy of Life, and we had lost the battle.

I am not arguing in the least against medical technology. I needed a heart valve replacement some years back, and without it I would certainly have died! But I reflect on those early years as a doctor because of the difficulty in finding either the time or confidence to relate to the person rather than the disease.

Communication skills have now become part of the medical school curriculum but enormous problems remain; doctors still think there should be an answer to every question. It is not easy to say ‘I don’t know’. Firstly, such an admission is not what the patient is hoping to hear. Secondly, it puts the doctor in

the less assured position of being a fellow traveller on the unpredictable journey of life - the patient has to tolerate the pain of uncertainty and the doctor, whose customary role helps relieve him of personal anxiety of illness and death by naming the problem firmly in ‘the other’, becomes the more vulnerable.

Yet joining forces by reaching out to the patient’s fear and pain brings the doctor a great opportunity for the medicine of healing, of ‘making whole’. It is no less important than cure, but has a different function. Feeling whole does not promise cure, but it enables a person to make the best possible recovery and, when illness cannot be relieved, to continue life with an intact sense of meaning and purpose. How different it might be if we could truly live those words of Reinhold Niebuhr, ‘God, give us grace to accept with serenity the things that cannot be changed, courage to change the things that should be changed, and wisdom to distinguish the one from the other’.

At this point, I had better say how I am using the term spirituality, since it is intrinsically bound up with wholeness. Among many definitions, it can be described as the experience of a deep-seated sense of meaning and purpose in life, a wholeness that brings with it the feeling of belonging, harmony and peace. It entails searching for answers about the infinite, and is particularly important in times of stress, illness, loss, bereavement and death. For some people, including those with religious beliefs, this sense of belonging is found explicitly in relation to God as the ultimate source of love.

To see why our medical care is so devoid of spirituality and so mechanical in orientation, we need to understand its roots in the Newtonian science of the last three hundred years. It happens that Isaac Newton was both a great empirical scientist and a deeply religious man, but his research into the properties of physical matter were taken to mean that God as the prime mover had to be located elsewhere, beyond a mechanistic universe, and such a remote God could hardly be expected to influence the workings of the human body except by means of occasional miraculous (inexplicable) healing.

By the end of the nineteenth century, disease had become identified with organ pathology, and the subsequent discovery of bacterial infections, biochemical, degenerative and congenital disorders, cancer and other conditions all reinforced this materialist perspective. God was dismissed by science as irrelevant, with the Church ousted from medical care except for providing comfort, offering spiritual guidance to the afflicted and administering the last rites.

Psychiatry as science of the mind

Psychiatry was borne out of neurology in Europe at the end of the nineteenth century with this same emphasis on the physical basis of disease. For example, neurosyphilis had been demonstrated to cause mental changes resulting from damage to the brain, while porphyria and vitamin deficiencies were shown to affect mental functioning. Such evidence persuaded Emil Kraepelin, a pioneer in the history of psychiatry, to classify mental illness into the two main categories, schizophrenia and manic-depressive disorder, the assumption being that the underlying causes must be physical and in time would be elucidated.

These two major mental illnesses do indeed respond to pharmacological treatments and most psychiatrists believe that they have a basis in vulnerable brain chemistry, though the causes are as yet unknown. But this emphasis led many psychiatrists to treat the numerous and varied disturbances of mood and thought as being indicative of mental disorder similarly requiring medication. General practice too, has been influenced by this climate of opinion; all too often the prescription serves a ritual function, a poor substitute for the time needed by patients to talk, be heard and understood.

At the other extreme, what about Sigmund Freud's remarkable contribution to the study of the mind? Freud's early expectation that neurosis would similarly prove to be founded in brain dysfunction never materialised. Instead, psychoanalysis ran for a hundred years parallel to mainstream psychiatry. This epic approach to the study of the psyche elegantly charted the conscious and unconscious reaches of the human mind but unfortunately it simply hasn't worked for serious mental illness.

In many departments of psychiatry today, in addition to physical treatments, a range of symptom-orientated psychological approaches is on offer. Psychoanalysis paved the way for shorter-term psychodynamic treatments; behavioural psychology has led to cognitive-behavioural therapies; family therapy is largely based on systems theory. Yet with the exception of the transpersonal approach, to which I shall come later, such therapies rarely stray beyond the pragmatics of everyday life. The big questions about birth, life, death, what it is all for, why must we suffer, all those deep concerns that disquiet the troubled mind, generally have no place in which to find voice, and so don't get raised. Yet we know that such concerns frequently do come the way of the psychiatrist if only the interest is shown.

Psychiatry as science without soul

In drawing attention to the schism that shaped Western science, I have painted a bleak picture of medicine, and psychiatry too. Of course, there are countless physicians and surgeons who intuitively and compassionately care for the 'whole person'. But schisms, conscious or otherwise, are intrinsic to the reductive-analytic methods of Western science. These days, every specialist knows more and more about less and less. We know that the whole is always greater than the sum of the parts and yet the focus increasingly is on the parts.

From general medicine I moved to the renowned Maudsley hospital and Institute of Psychiatry in London. The academic and research base was first-class and the consultants were leaders in the field. But it seemed that the mind had got divorced from the body, which had been left somewhere behind. Liaison psychiatry was in its infancy and more or less confined to seeing patients with overdoses admitted to King's College Hospital across the road, or unexpected cases of delirium tremens on the medical and surgical wards. Psychosomatic medicine, too, seemed to have run out of steam, all this being prior to the discovery of psychoneuroimmunology.

As psychiatrists, we earnestly debated the finer points of diagnosis much along the same lines as in general medicine. But the mind is not the body, and I

was struck how often this seemed to be about gleaning intellectual satisfaction from the work rather than of itself having much bearing on management and treatment, which was usually pretty obvious. If anything, the clinical environment had become more remote than ever - patients not so much got talked to as got talked about.

Psychiatry seemed to have no soul, although at the time it would not have occurred to me to put it that way. Instinctively, I turned to psychoanalysis. Aside from personal issues that I wanted to explore, the Maudsley psychotherapy department was the one place where enough time was given to sit with, and really 'be with', your patient. I realised at once that this was what I had come into psychiatry for.

The search for soul

Psychoanalysis, and subsequent training in group analysis, took up a lot of my time over the next few years. It was a love affair I remember with great affection. Sigmund Freud had an answer for just about everything that lay between birth and death, and it all made sense. My intellect was fired, while my admiration for Freud was unbounded. It served its purpose – I worked hard, became a consultant and was able to help a good number of patients. But later I came to see that Freud had for me been an irresistible father figure, and that had I remained obedient to his will, I would never have left home and made my own way in the world.

The work of Carl Jung barely got a mention at the Maudsley and I wondered why, until I read about his exile by Freud (if you go round Freud's house in Vienna, where the walls are lined with hundreds of photographs of Freud, his family, friends and colleagues, there is not one picture of Jung, the disciple who Freud had once seen as his natural successor). My curiosity aroused, I started to read Jung and I found myself engaged with a mind as profound as Freud's, with one great difference. Jung sought to understand man not only as the product of his childhood but endowed with an ineluctable spiritual birthright.

This opened a door for me. Patients had not infrequently brought to me what I would these days call spiritual concerns - deep searching questions about the whole meaning and purpose of life, especially of suffering. I had been inclined to interpret these in relation to problems that had been encountered in childhood and subsequent relationships difficulties and I was not always wrong. But sometimes I knew I had missed the boat, and it was no good ascribing it to 'resistance' on the part of the patient. I began to see that my need for an all-explanatory psychology of humankind was a defence against the unknown, not the small unknown of the human unconscious mind but the greater unknown that goes way beyond birth and death.

About this time, I began training in psychodrama. To my surprise, it found places in me that analytic therapy had never reached. Memories, dreams and reflections of my own erupted with full force, and could be dramatised without the constraints of having to sit or lie down, (the golden rule of analytical therapy). The effect was to connect body with mind and to discover that the body has memories

of its own, going back to the womb, let alone getting born! Rather than experiencing myself as an observer of life, I began to live more of it for myself - for psychodrama sees life as just that, a drama to be played out in which we each are protagonists in a script we simultaneously write, direct and watch.

When doing psychodrama, time is divided between enacting, as oneself, the scene of the memory, and role reversing with others whose perspective can add to an understanding of the situation being re-played. But the 'other' needs not be of human form, as I found out in one of the first workshops I attended. I recall a woman had been deeply embittered by the loss of her son years before. In the session, she found herself back at the roadside scene of the car crash in which he had been killed. Weeping in despair, she cried out 'God, why have you done this to me'. The therapist instantly told her to reverse roles with God. At once this mother's face changed, becoming calm and composed, her sobbing ceased and as God she said with immense dignity, 'I have done nothing to you. Your son chose to die, so that he would not suffer any more. Be happy for him and thankful for his life which brought you joy.'

This involuntary utterance surprised the woman as much as it did us. She could see the meaning of it perfectly and began for the first time since her son's death to mourn without the bitterness that had held her captive for so long. She could at last start to heal.

I have detailed this event because it was a defining moment for me. I perceived that such deep wisdom brings with it the power to heal; I saw the harnessing of the strength and beauty of the soul and that without it, no amount of psychological insight alone can heal us of the traumas of life.

I began to ponder the limitations of dynamic psychotherapy. For instance, therapists talk a great deal about projection and splitting as pathological defences against psychic pain, while entrusting recovery to the resolution of the transference by way of interpretation [1]. This frame of reference is invariably one of patient as child and therapist as parent offering what has been called 'the corrective emotional experience'. Standing in loco parentis is no small undertaking, but more worrying still, the dependency needs of the patient too often result in the therapist being perceived as omnipotent, patently a God-like role. Yet therapists rarely respond to the deepest and most heartfelt questions of all, 'why am I here, what is it for, what happens when I die, why must I suffer?' Most will studiously avoid disclosing their own doubts and dilemmas in order to preserve the supposed transference need for a wise and knowing parent. The tendency is rather to interpret these fundamental existential concerns according to the analytical method, along with everything else.

[1] The analytical method encourages the emergence of unresolved childhood emotions, which get unconsciously projected on to the therapist (a process called transference). The therapist remains as neutral as possible in order to be a 'blank screen' for such projections. By means of interpretation, the therapist endeavours to help the patient understand what is happening, and to own such feelings instead of splitting them off and projecting them onto himself and others. The process is often painful and good 'parenting' is required on the part of the therapist to enable the patient to feel sufficiently secure to cope with what is going on.

Healers, energy and consciousness

I have learned that in life nothing happens by chance. Around this time I met a number of healers and was struck by the good results they were having across a range of physical and emotional conditions. I decided to learn more and applied to train at the College of Healing where I met many healers and 'intuitives' who could directly perceive the human energy field or 'aura'. From a medical point of view, the therapeutic effects of hands-on healing are put down to the 'placebo effect', attributable to suggestibility. But what if the 'energies' being employed are real enough, but beyond the instrumentation of our current science to detect?

There is now very good empirical evidence that healing works. Double blind trials have excluded suggestibility as the mechanism. Quantum entanglement may hold the key; experimental physics is now challenging what was formerly regarded as the impenetrable limits of space-time. It is being argued that the ground substance of consciousness is non-local and that far from consciousness being generated by each brain, it is a unified field in which we are all immersed. Indeed, top-down theorists hold that matter is nothing less than precipitation of energy, which has (cosmic) intelligence inscribed in its very substance.

Such a cosmology describes a participative spiritual universe, fundamentally conscious in design, and very possibly evolving so as to know more of itself. If holographic theories of the universe are to be believed, the astonishing diversity of life on our little planet reflects a principle of differentiation manifested throughout the length and breadth of the cosmos, while our capacity for love likewise reflects the principle of unity, the oneness of all that is. The quantum image of wave and particle touches us because in it we discern the eternal dance of *yin* and *yang*, the emanation of a divine source of incomprehensible creativity.

We generally take the world of our ordinary sense perception for granted; after all, it comprises the 'consensus reality' of everyday life. But I began to see that there is actually no such thing as reality, in and of itself. All is perceived or construed in line with a person's subjective disposition. Most of us see and hear things the same way (in line with what quantum physicists call the collapse of the probability wave). But it is not always so, as the accumulated body of research into paranormal phenomena now demonstrates.

This raises another difficulty for psychiatry, for how then should we distinguish between mental illness and paranormal experiences, not least between psychosis and spiritual crisis? To make matters more complicated, there can be an overlap between the two.

One way is to postpone making a judgement about the status of a symptom while exploring what value it holds for the person and whether it stands to help the person find a more meaningful and purposeful life. Breakdown may yet turn into breakthrough.

This takes us away from the notion of disease, which is an objective measure, to that of illness, concerned more with the impact of physical or emotional adversity on how a person is functioning. This, again, is highly

subjective, for people can be ‘well’ in themselves even as they are dying; wholeness of being and fulfilment of the moment can be of far greater importance than the disease process. How often we overlook the precious ‘now’ and instead worry about a future that must in any case, eventually bring death our way!

The life instinct is usually a strong one and the promise of cure is, of course, always welcome news. It restores, in the short term, a sense of immortality that distances us from that day of reckoning. But while death has aptly been described as the one appointment no one is in a hurry to keep, the materialist reality of our time makes the inevitable ending of life, including the loss of loved ones, a tragic and irreparable parting of the ways.

Loss as transition

The death of someone close is often the precipitant of breakdown in an already vulnerable person. Yet the belief that consciousness ends with death is merely one of cultural conditioning. We can appreciate the many benefits that three hundred years of ‘scientific realism’ have conferred, without succumbing to its materialist ideology.

In any event, there continues to be intense speculation about life after death, and the many views articulated, both secular and religious, probably reflect nothing more than the very partial view we get from the embodied mind and the associated limitations of the human brain.

Bearing this in mind, spiritual psychiatry sets out to help a person value, trust and explore the authenticity of their own experience as fully as they can. It follows that the psychiatrist should avoid making assumptions or judgements, but instead to follow wholeheartedly the thoughts and emotions of his patient. No counter-culture proselytising is required; this would be to replace one kind of conditioning with another. Fortunately, since our innate archetypes remain alive and well, it is only necessary to ask with genuine interest what a person would hope to be the case, and to give support to that possibility, for it cannot be disproved.

For example, when a bereaved patient entreats ‘if only my mum were still here’, it may be helpful to proceed by finding out what it is that person is most needing, and then to urge him[2] to take the chance of talking with mum, by asking him to close his eyes, to imagine her there in the room, and to go right ahead and speak with her out loud. When he has done so, the patient is asked to sit for a moment longer, eyes closed, and listen to, or simply experience, what may come back. Sometimes it is a verbal response, or it may be in silence, a loving embrace.

Crucial unfinished business can be completed this way, often with the farewell that had not been possible in life. Usually the person will have had a profound sense of the presence of the deceased, or even to have seen or heard them.

What does this actually say about life after death? It says everything and nothing, depending on your point of view. It can be understood on the psychological level, on the spiritual level, or both. Either way, it breaks the

[2] Both the male and female gender is used interchangeably for the purpose of convenience.

terrifying finality of death, because the mind has been helped to transcend the customary limits of space-time. And if there has already been a sighting of the deceased (known in psychiatry as a pseudo-hallucination), the spiritual affirmation will be all the more profound.

For some people, spirituality means finding the greatest depth of meaning and purpose in their existence without reference to other-dimensional realities. In my own case, however, my researches had led me to see the soul as a scintilla of eternal consciousness that chose to incarnate into this world in order to learn and grow. I was curious to find out more about my soul journey and it led me to the study of 'past life' regression, both academic and experiential.

The transpersonal perspective

Transpersonal phenomena arise in an 'altered' state of consciousness. But this does not have to be a trance state, or by taking psychoactive drugs. There are many subtle changes in consciousness, for instance in reverie, stilling of the mind as in meditation and prayer and the hypnagogic state, when the bounds of space-time melt away. If someone brings an inexplicable symptom, such as a fear of suffocation, and after taking a history that gives no other clue, he is invited to close his eyes and to 'go into' that feeling of suffocation and describe what is happening, and if he suddenly finds himself in a burning house and cannot escape, a scene which ends in death, and if he then find himself leaving his body, just as described in the near-death literature, before returning to the here and now and is left with the vivid impression that the fear of suffocation is an imprint of a trauma from another place and time, and if he gets better as a result of having had such a realisation, who is to say what has really happened? (I should add that such 'memories' arise equally often in people who have no thought of re-incarnation.) From the clinical perspective, the important thing is that the treatment worked.

The same principle applies to 'spirit release' therapy, in which the therapist engages with an 'entity' that has attached to the patient, and releases it into 'the light'. When a patient gives a history suggestive of such an attachment, it is not difficult to dialogue with the 'earthbound spirit', much as takes place in psychodrama or gestalt therapy. The patient finds herself speaking as the spirit, divulging how and when it came to be attached, and why it has got stuck. Such earthbound spirits are in general not so much malicious as lost or confused, often because their lives ended in violent death, or under the influence of drugs. This therapeutic intervention is a far cry from exorcism and calls instead for a compassionate understanding of the plight of both patient and attached spirit. The spirit is then guided on its way with love, and help from above.

Transpersonal therapy is open to abuse, just as any other form of treatment, and ethical considerations have to be high on the list. But while we may argue about the true nature of such soul-centred work, what we do know is crucial to the outcome is that the therapist must have a genuine and compassionate desire to help patients in need, and be fully willing to enter with them into their world.

The next step

In mental healthcare, treatment is largely pragmatic, based on the prevailing bio-psycho-social model of our times. It is a good working model yet spirituality, the highest function of the imaginal mind, has got left out. This is something of an irony since psyche means spirit or soul, and it is a lack that urgently needs putting right. Apart from the importance of encouraging patients to feel able fully to confide in their psychiatrists, research over the last fifteen years has shown that spirituality is good for both mental and physical health. So we need to develop a 'bio-psycho-socio-spiritual' model of healthcare.

It struck me that we could make a start on this in the United Kingdom by setting up a spirituality and psychiatry special interest group in the Royal College of Psychiatrists[3]. Since 1999, we have attracted a membership of more than twelve hundred psychiatrists. Our website is in the public domain and the subject of spirituality and mental health is now a stated concern of the College[4].

None of this need be remote or esoteric stuff. A psychiatrist can easily include taking a spiritual history as part of the consultation process. Just a few questions asked with sincerity and interest will elicit a person's important beliefs, and how they affect the way he sees the world and the problems and challenges of life. And when a person is searching for answers that go beyond the limits of psychology, there are times when the psychiatrist may usefully go with his patient into the transpersonal realm. At all events, the psychiatrist who can be a caring confidant for his patient's soul-searching will be amply rewarded, for it is only required of him to be fully 'present'. The soul in its wisdom will find the place of healing and it is our privilege to be able to help give it the occasion.

For further reading, see Dr. Andrew Powell's publications on Spirituality and Psychiatry at: www.rcpsych.ac.uk/college/SIG/spirit/publications/index

This publication is now a chapter in 'Spirituality, Values and Mental Health' (2007) Eds: Coyte E, Gilbert P, and Nicholls V. published by Jessica Kingsley. For further information and purchase, go to: http://www.jkp.com/catalogue/book.php/isbn/9781843104568

[3] See www.rcpsych.ac.uk/spirit

[4] See www.rcpsych.ac.uk. The Royal College of Psychiatrists Homepage, Mental Health Information drop-down menu, 'Mental Health and Spirituality': leaflet available as pdf. download. Printed version available on request from the College, tel: 020 7235 2351 ext 259. e-mail: leaflets@rcpsych.ac.uk