

Spiritual aspects of psychosis and recovery

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The spiritual dimension cannot be ignored, for it is what makes us human
Victor Frankl (1973)

How do we make sense of spirituality and the psychotic experience? Psychiatrists often struggle to make sense of, and to make progress with, people suffering from psychosis and to support their personal journeys towards recovery. Yet while psychosis is at the heart of psychiatry, psychiatrists have often dismissed or regarded with distrust the spirituality that is valued by many of their patients. In this paper I will explore these issues from three perspectives; the psychiatrist's understanding of psychosis and spirituality; the role of spirituality in individual's recovery and the implications for clinical practice - practical spirituality.

What is spirituality?

*The Tao that can be told is not the eternal Tao.
The name that can be named is not the eternal name.*
Lao-Tzu (c.604-531 BC)

These opening lines from the Tao Te Ching - the book of the Way - capture the difficulty of defining the ineffable quality of spirituality; yet we do need a definition. Cook (2004), having reviewed a number of ways of defining spirituality, has drawn up the following definition, which expresses its essence.

Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as relationship with that which is intimately 'inner', immanent and personal, within the self and others, and/or as relationship with that which is wholly 'other', transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values.

William James described something similar here in Edinburgh when he gave the Gifford Lectures on Natural Religion 1901-02 which were later published as 'The Varieties of Religious Experience'.

‘...feelings, acts and experiences of individual men in their solitude, so far as they apprehend themselves to stand in relation to whatever they consider to be divine ...’

Yet spirituality need not be the preserve of religion. Spirituality and religion are often confused but they are not the same. My understanding is that the spiritual is pre-eminent and inclusive and that the guiding purpose of all religions is to connect us to the spiritual (Remen, 1993). Religions offer ways to make this connection, through community based worship and through a particular set of beliefs (dogma) and sacred traditions. When there is a lack of respect for others holding different beliefs, however, religion can be used as a social and political tool leading to intolerance and divisiveness. There is in all of us a spiritual quality that goes beyond what we can measure or define – an aspect that is an awareness of the transcendental or of the ‘divine’. For many people spirituality is reflected in their religious practice, for others it may be in something else such as music, poetry, nature or art. This spiritual quality is as valid for our patients as it is for ourselves.

Psychosis and spirituality

Meaning and purpose in life are at the core of both psychosis and spirituality - a sense of coherence. Both are concerned with the person’s inner experience, stretch reason to its limits and share a sense of mystery.

Psychosis often arises in adolescence or early adult life, when the individual is developing a sense of self (schizophrenia has been called the ‘sickness of the self’, (Cullberg 2006 p. 127)), questioning established certainties, myths and beliefs; exploring or experimenting with new ones and seeking their own sense of purpose and meaning; grappling with the conflicting demands of external expectations and opportunities while at the same time trying to fathom their internal world. Psychosis is also found disproportionately in both first and second generation migrants (Hutchinson & Haasen, 2004) whose situation is often characterised by a new and challenging external reality in terms of language, culture and social support. In psychosis meaning and purpose may become distorted. The elaboration of delusional beliefs into systems, in which it is possible for the person to reconfigure their identity, are often significantly accompanied by a subjective experience of meaning and purpose - the comforts of madness as this example shows (Roberts, 1991).

Alan, a friendless man living in poverty, believed himself to be an unempowered Messiah and was waiting to be called forward as the Second Coming. He attended church each week, positioning himself near the altar so as to receive the genuflections of communicants as worship. He believed that the many tourists that filled his town in the summer were pilgrims.

In the development of psychosis a person's perception of his world can be turned 'inside out'; *'from a neglected, peripheral person without any power to make an impression on the world that person suddenly becomes its centre'* (Cullberg, 2006). This has been described as a Copernican revolution and is often accompanied by a fragile but extreme certainty so that the person's world '...has changed to the extent that a changed knowledge of reality so rules and pervades it that any correction would mean a collapse of Being itself, in as far as it is for him his actual awareness of existence' (Jaspers 1963).

When, in a research study, seventeen people with longstanding complex systems of delusional belief were asked to imagine what it would be like to recover or 'go sane', fourteen gave a range of strongly felt negative answers and collectively they considered the prospective loss of their beliefs as very threatening (Roberts, 1991). Eight said they would have nothing to live for or that they would be destroyed, eight viewed the prospect as 'terrible', 'depressing' or 'frightening', five anticipated entering futility, emptiness, bleakness or becoming inert or destitute, three felt that they would be cut off from others and two believed they would go mad. This paradoxical finding of meaning and purpose in delusional belief (illness) and anticipation of emptiness and futility on recovery is consistent with Jaspers warning quoted above about a collapse of Being itself. We are familiar with the depression that can occur as a person recovers from psychosis but there may be a spiritual aspect to this too as the person adjusts to a loss of faith in their beliefs.

In the clinical setting we commonly find that psychosis is a state of disruption and disturbance characterised by fear and what could be called the discomforts of madness:

'There are days when I wonder if it might not be more humane to leave the schizophrenic patient to his world of unreality, not to make him go through the pain it takes to become part of humanity. These are the days when the pain is so great. I think I might prefer the craziness until I remember the immobilising terror and the distance and isolation that keeps the world so far away and out of focus. It is not an easily resolved dilemma'

(Anon, 1986)

Making some sense of psychosis

The language and form of spirituality and religion are endemic in expressions of psychosis, even for the non religious; meaning and purpose become distorted in psychosis with the loss of a coherent narrative. So how do we make sense of delusions; and whose meanings count? Do we follow the psychiatrists who see religious or spiritual explanations as delusional ideas that are attributable to the illness, serving simply as one of its more characteristic symptoms: or do we continue to attend to the person trying to make sense of his or her experiences? (Roe & Davidson 2005).

Some people view their madness as a spiritual journey. But can religious or spiritual experiences be distinguished from psychotic ones? A number of studies have found it impossible to differentiate between mystical experiences and psychosis solely on the basis of phenomenological description (Greenberg et al. 1992, Jackson & Fulford 1997, Saver & Rabin 1997). Peters (2001) concludes that the overall findings of these and other studies support the idea of a continuum from normality to psychosis and the need to consider the multidimensionality of delusional beliefs. In general little difference is found between the beliefs and experiences of the psychotic and the spiritual in form or content but it is the way in which the experiences are evaluated that distinguishes them. What seems to be important is the way in which the psychotic phenomena are embedded in the values and beliefs of the person: 'It is not what you believe but how you believe it'. Distress and unwanted preoccupations characterise psychosis, whereas spiritual experiences may be sought after and are more often associated with positive life changes (Greenberg 1992, Lukoff 1985). The kinship and difference between mystical and psychotic states is captured in essence here by Jelaluddin Rumi, the 13th Century Persian Sufi (Barks, 1993).

*The mystic dances in the sun,
hearing music others don't.
'Insanity,' they say, those others.*

*If so, it's a very gentle,
nourishing sort.*

Recovery

A meaning-centred approach is central to recovery from psychosis. *'Personal recovery involves much more than losing symptoms. It involves becoming a person again, regaining a personal life that has some value and meaning'* (Whitwell, 2005).

Swinton (2001) has described a number of Spiritual Needs all of which are reflected in the definition given at the start of this paper.

- Values/structures of meaning - hope, faith, purpose, dealing with guilt, forgiveness
- Transcendence - creativity, reaching God, dimensions beyond self
- Relationships - therapeutic presence, possibility of intimacy
- Communication - telling stories, listening and being listened to
- Affective feeling - comfort, peace, happiness, reassurance

If there is indeed a spiritual dimension in us all, then it follows that spiritual needs do not vanish just because diagnosis of psychosis has been made. Indeed it was reasoning such as this that led to the founding of The Retreat in York (Tuke, 1813) at the end of the eighteenth century, based on the Quaker belief that there is 'that of God' in everyone. Yet some patients with psychosis report being afraid

to discuss spiritual issues with psychiatrists for fear that their concerns will be dismissed as illness. Their spiritual needs may be less evident than those of people without psychosis and indeed there may be a relationship between the stage of the patient's recovery and the importance that they place on spirituality in their lives. Those who are so unwell as to be subject to compulsory care and treatment may be at that stage, in a Maslowian sense, when other matters appear more important than spiritual ones (Dinniss *et al*, 2007). It also depends how questions concerning spirituality are put, and we must be careful to avoid premature assumptions as this example shows.

Julie, a young lawyer, during her first pregnancy suffered a recurrence of an earlier depression; she was anxious and fearful and gave up work. As her pregnancy continued so her mood worsened and she began psychotherapy. Before her child was born an interpretation was made in therapy that she was having murderous thoughts towards her unborn child. Her condition deteriorated with the emergence of paranoid delusions that she was being poisoned which progressed to a serious puerperal psychosis. She had been brought up as a Roman Catholic and, as she later explained, had been taught that thoughts could have the moral culpability of actions. She believed that she had killed her unborn child. Once she recovered she was very apprehensive about further psychotherapy and believed that the therapist had not taken enough time to find out about her religious beliefs.

What is important here is not so much 'taking a history' as reaching a shared understanding, being aware of the difference between 'my story of you' and 'your story of you' (Hunter, 1991). This collaborative exploration of the spiritual dimension is a dynamic process in which meanings may change depending on the severity or stage of the disorder. But it can be difficult to maintain this collaboration in the pressurised 'unreal' setting of a psychiatric ward while in the company of a person in the confusion of their psychotic reality. Our clinical experience often makes us aware of the dark side of spirituality, challenging the prevailing assumption that the relationship between spirituality and health is mainly positive.

What are these negative aspects of spirituality and religion? Spiritual practice, meditation, yoga and prayer for example, can trigger psychotic experiences as well as helping practitioners to cope. 'Spiritual practice related experiences' with psychotic features are included as one category of Visionary Spiritual Experience (VSE) by Lukoff *et al* (1998) and it seems possible that those who engage in 'New Age' spiritual practices without a supportive structure may be more vulnerable to psychotic breakdown. Organised religions, in common with any organisation, can be vitiated by the abuse of power and the effects can be devastating. In a cult, the person may be subjected to a high degree of control by a leader who prevents any contact with the outside world. The drive of 'true belief' (rather than the seeming uncertainty of compassion) may lead to various

kinds of cruelty which may result in psychotic breakdown. Sexual and physical abuse by priests and ministers of religion may not be a new phenomenon but there is now an increasing understanding of trauma both in the aetiology and in the management of psychosis (Read *et al*, 2004). The social support that religious communities offer may be perceived negatively if the person has had abusive experiences, or the community may be unable to offer support when it is needed due to their fear of mental illness or the adverse way in which they may view it.

How should we respond?

Exhibit D

*Here is my brain
in a pickling jar*

*Note the tired synapses
Observe the threadbare nerves*

*Then tell me, if you will
where is my love of rain*

*my craving for colour
my vanishing dream?*

This poem by Julie Leibrich (2002) reminds us that for our patients a scientific approach is not enough or, as Swinton (2001) puts it, 'the complexity and uniqueness of human existence cannot be captured by statistical norms'. Our professional training focuses on valuable technical knowledge, skills and experience, essential if we are to think clearly about how to help our patients; but care and compassion are also vital in psychiatry; rigorous science and compassionate humanity are both needed in a good physician. Potentially every form of therapy has a spiritual dimension, although this can often be difficult to hold in mind. The positive expressions of spirituality: patience, kindness, compassion, humility and goodness, are reflected in all aspects of life. If we provide truly humane care there will be a spiritual aspect to all that we do, a practical spirituality.

Relationships and communication are vital in this. Rachel Perkins (2006: p. 119) has talked about the importance of 'hope inspiring relationships'. Cullberg also acknowledges the importance of relationships at the 'turning-point' in recovery:

'in a positive sense to tire of dependence on inner destructive forces and to decide to depend on one's own potential is a process that sometimes bears a resemblance to Christian parables of conversion. Often the event

is conveyed through a personal relationship with a carer, a partner or someone who believes in the person's potential and who does it at the right time' (Cullberg, 2006 p. 166-7).

But fear can get in the way and impede communication, both the fear experienced by the patient and the fear of the doctor or therapist. So we may need other 'languages', drama, art, literature [especially poetry] and music; some way for the person to turn their pathology round in a productive and creative direction: to 'give oneself over to something bigger and more important than oneself' (Chadwick 2008). Vincent van Gogh (1888) expresses the importance of the creative aspect of spirituality. 'I can very well do without God both in my life and in my painting, but I cannot, ill as I am, do without something which is greater than I, which is my life – the power to create'. The opportunities we offer patients to explore this dimension should remain 'live' and not become **just** 'therapy' or 'occupation', important as these are. Murray Cox's initiative bringing Shakespeare, 'this great and amazing libertarian,shaking his spear at ignorance and talking about spiritual things but in such an open way that you can take it as you like it', to offender patients in Broadmoor is an excellent example (Cox 1992 p32). Therapeutic interventions need not be explicitly spiritual; creative writing, music, gardening empathic listening and narrative therapy are all ways in which spiritual connections can happen. 'Spirituality' is not a special form of treatment, there are no technical routines that are inherently spiritual – it is the way in which the work is carried out that imparts the spiritual quality.

Does it make a difference?

'The recognition of the spiritual side of my illness and the taking it seriously by clinicians and social workers were extremely important in my recovery.' (Chadwick 2001). Paul Lysaker, from his experience of qualitative research and working psychotherapeutically with people with severe psychosis, observes that *'People recovering from schizophrenia may need to develop a sense of hope and self-reliance before they can fully use any information a practitioner can offer them. What practitioners say and how they say it are both important'* (Lysaker & Buck, 2008).

The next two clinical examples are ones that I think help to illustrate the ways in which paying attention to the spiritual dimension can make a real difference to people's lives. The first highlights the importance of an awareness of spirituality in relation to assessment and treatment.

Daniel, a college lecturer, with an alcohol problem and episodes of psychosis, had made a serious suicide attempt after a course of ECT. The staff team had asked the new consultant to see him and discharge him, as they had decided he was a psychopath. They also believed that it was the job of the consultant to take the responsibility for that decision as they thought that there was still a risk of suicide but they did not know what else

to do. The consultant listened to him and discovered two important things clinically that had been overlooked or forgotten: firstly that he believed that ECT was a 'last resort' and since it had failed to help him there was no hope for him and secondly that he had poor concentration. He was no longer able to do the Guardian cryptic crossword – a level of intellectual activity which the ward test for concentration was not sophisticated enough to register. The consultant also learnt that he was a deeply religious Roman Catholic who had doubts about his faith and welcomed the opportunity to talk about this. A change of antidepressant appeared to make a significant difference to his mental state and he was slowly able to put his life back together again. But also he was able to develop a trusting relationship, he felt understood and accepted by the process of simple listening and acceptance (and he regained his ability to solve the crossword!). The lack of ability of the team to 'tune in' to this man's 'larger meanings' might well have cost him his life.

The final example is about the importance of relationships and the development of trust.

Lillian had a long-term intractable recurrent psychosis. She had been in and out of hospital for years and was referred in her mid '50s for long-term hospital care as her team were finding it impossible to maintain her in the community. She was angry about this view and wanted to go home. Instead of forcing her to stay, the new team worked with her towards returning home and remaining well there, which she achieved. After about a year a member of the referring team said 'I don't know what you're doing but I'd like to bottle it'. Well, maybe some of it doesn't go into a bottle. What I think they were doing differently was attending to key elements of the spiritual dimension, developing a trusting relationship, really listening, sharing in and bearing some of the pain and loss with both the patient and her 80-year-old mother. This meant, for example, avoiding 'pathologising' all her behaviour, not rushing to use the Mental Health Act in an antagonising way, being open and meeting on equal terms as human beings.

When working with people suffering from psychosis, a practical, grounded, 'recovery-oriented' spirituality that incorporates humanity and compassion while accepting the integrity of personal experience is invaluable. In this short paper I hope I have touched on some of the complexities in the relationship between spirituality and psychosis and highlighted the importance of having an awareness of the spiritual both in our practice and in our understanding of psychosis.

References

- Anonymous (1986) 'Can we talk?' The schizophrenic patient in psychotherapy. *American Journal of Psychiatry*, 143, 1, 68-70.
- Barks, C. (1993) *Rumi. Birdsong: 53 short poems* (trans C Barks) p 24. Athens GA: Maypop Books.
- Chadwick, P. K. (2008) *Schizophrenia: The Positive Perspective (Second Edition) – Explorations at the Outer Reaches of Human Experience*, Ch 6, London and New York: Routledge.
- Chadwick, P.K. (2001) Sanity to Supersanity to Insanity: A personal journey. In *Psychosis and Spirituality: Exploring the new frontier* (ed I. Clarke), Ch 5, pp75-89, London and Philadelphia: Whurr.
- Cook, C. C. H. (2004) Addiction and spirituality. *Addiction*, 99, 539-551.
- Cox, M. (1992) *Shakespeare comes to Broadmoor*. London: Jessica Kingsley.
- Cullberg, J. (2006) *Psychoses: an integrative perspective*. London: Routledge.
- Dinniss, S., Roberts, G., Hubbard, C., Hounsell, J., & Webb, R. (2007) User-led assessment of a recovery service using DREEM *Psychiatr. Bull.*, **31**: 124 - 127.
- Frankl, V.E. (1973) *The Doctor and the Soul: from psychotherapy to logotherapy* (trans R & C Winston) New York: Vintage Books.
- Greenberg, D et al (1992) Mysticism and psychosis: the fate of Ben Zoma. *British Journal of Medical Psychology* **65**: 223-235.
- Hunter, K. M. (1991) *Doctors Stories: the narrative structure of medical knowledge*. Princetown, New Jersey: Princetown University Press.
- Hutchinson, G., & Haasen, C. (2004) Migration and schizophrenia *Social Psychiatry and Psychiatric Epidemiology*, **39**,5, 350-357.
- Jackson, M. (2001) Psychotic and spiritual experience: a case study comparison. In *Psychosis and spirituality: Exploring the new frontier*. (ed I. Clarke), Ch 10 pp 165-190. London and Philadelphia: Whurr Publishers.
- Jackson, M., & Fulford, K.W.M. (1997) Spiritual Experience and Psychopathology *Philosophy, Psychiatry, & Psychology*; **4**:1 pp. 41-65.

Jackson, M., & Fulford, K.W.M. (2002) Psychosis Good and Bad: Values-based practice and the distinction between pathological and non-pathological forms of psychotic experience. *Philosophy, Psychiatry, & Psychology*; **9**:4 pp. 387-394.

James, W. (1902) *The Varieties of Religious Experience*. pub 1960 London: Collins Fontana Library.

Jaspers, K. (1963) *General Psychopathology* (trans J. Hoenig & J.W.Hamilton), Manchester: Manchester University Press. The University of Chicago Press.

King, M.B. & Dein, S. (1998) The Spiritual Variable in Psychiatric Research. *Psychological Medicine*, **28**, 6, 1259-1262.

Lao-Tzu (c.604-531BC) *Tao Te Ching; the book of the way*. (trans S. Mitchell 1988). London: Kyle Cathie.

Liebrich, J. (2002) Making space, spirituality and mental health. *Mental Health, Religion and Culture*, **5**, 143-162.

Lukoff, D (1985a) Transpersonal perspectives on manic psychosis: Creative, visionary, and mystical states. *Journal of Transpersonal Psychology*, **20**(2), 111-139.

Lukoff, D. Lu, F. & Turner, R (1998) From Spiritual Emergency to Spiritual Problem: The Transpersonal Roots of the New DSM-IV Category. *Journal of Humanistic Psychology*, **38**(2), 21-50.

Lysaker, P & Buck, K. (2008) Is Recovery from Schizophrenia Possible? An Overview of Concepts, Evidence, and Clinical Implications. *Primary Psychiatry*. **15**(6):60-65.

Mitchell, S. & Roberts, G. (2009) Psychosis in *Spirituality and Psychiatry* (eds Cook, C, Powell, A and Sims A) pp 39-60 London: Gaskell.

Perkins, R. (2006) First person: 'you need hope to cope'. In: *Enabling recovery: the principles and practice of rehabilitation psychiatry* (eds G Roberts, S Davenport, F Holloway & T Tattan) pp112-124 London: Gaskell

Peters, E. (2001) Are delusions on a continuum? The case of religious and delusional beliefs. In *Psychosis and Spirituality: Exploring the new frontier* (ed I. Clarke), Ch 11, pp191-207, London and Philadelphia: Whurr.

Read, J., Goodman, L., Morrison, A., Ross, C., & Aderhold, V. (2004) Childhood trauma, loss and stress. In *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia* (eds J Read, L Mosher & R Bentall), pp. 9-20 Hove and New York: Brunner-Routledge.

Remen, N. (1993) On defining spirit. *Noetic Sciences Review*, **27**, 40.
Roberts, G. A. (1991) Delusional belief systems and meaning in life: a preferred reality? *British Journal of Psychiatry*, **19** (suppl. 14) 19-28.

Roe, D. & Davidson, L. (2005) Self and narrative in schizophrenia: time to author a new Story *J Med Ethics; Medical Humanities*; 31: 89–94.

Saver, J.L. & Rabin, J. (1997) The neural substrates of religious experience. *Journal of Neuropsychiatry and Clinical Neurosciences* **9**: 495-510.

Swinton, J. (2001) *Spirituality and Mental Health Care*. London: Jessica Kingsley.

Tuke, S. (1813) *Description of the Retreat, An Institution near York for Insane Persons of the Society of Friends*. Reprinted (1996) London: Process Press.

Van Gogh, V (1888) letter to Theo in *The Letters of Vincent Van Gogh* (ed M. Roskill 1963) p 286, London: Collins.

Whitwell, D. (2005) *Recovery beyond Psychiatry*. London: Free Association Books.

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