Psychiatry and Spirituality – the Forgotten Dimension

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Introduction

The historical split between religion and science has had profound implications for the world we live in, culminating in a twentieth century culture modelled on the mechanistic, Newtonian paradigm of reality. Yet we are now in a position to compare this paradigm with the revolutionary implications of quantum physics, which reveal that we partake of a living spiritual universe, one in which not matter but consciousness is the driving, creative force. Whether we choose to call it the Godhead, or Atman, or the Dao, we have the prospect of bringing together science and spirituality in ways that could not have been imagined a hundred years ago.[1,2,3]

In 1999 the Spirituality and Psychiatry Special Interest Group in the Royal College of Psychiatrists was founded and over the four years since, close to 700 psychiatrists have become members of the group.

Our work has been greatly helped by empirical research in the USA over the last decade, showing that spirituality is good for your health. Modules on spirituality have been introduced in over 90 US medical schools. In this country we have just one up and running to date, pioneered by John Swinton at Aberdeen University.[4] A second initiative is now being going ahead at St. George's Hospital Medical School, London.

A principle aim of our group is to influence the content of the training curriculum for psychiatry in the UK, and the range of clinical skills acquired. The problem here is that psychiatrists are not given any guidance about how to handle spiritual matters when they arise in the consultation and because they feel unskilled, the tendency is to gloss over such things.

Yet it turns out that the majority of people coping with mental disorder do find themselves turning to their spiritual and religious beliefs to help them pull through. For instance, in one survey of psychiatric patients, over half went to religious services and prayed daily, and over 80% felt that their spiritual beliefs had a positive impact on their illness, providing comfort and feeling of being cared for and not alone. Yet over a third of them did not feel able to discuss such things with their psychiatrists.[5] Perhaps their intuition was spot on, for other research shows that whereas in the general population over 90% have belief in God or a higher power, around only a third of psychiatrists and psychologists hold such beliefs.[6] (The danger here is that psychiatrists may think they represent the norm, when it is they who are atypical in this regard).

Research into Spirituality and Health

Health, according to the World Health Organisation's constitution, is *'a state of complete physical, mental and social well-being, not merely the absence of disease'*. The WHO report continues: *'the health professions have largely*

followed a medical model, which seeks to treat patients by focusing on medicines and surgery, and gives less importance to beliefs and to faith – in healing, in the physician and in the doctor-patient relationship. This reductionism or mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realise the value of elements such as faith, hope and compassion in the healing process'.[7]

The healing power of these spiritual values applies to mental and physical afflictions alike. In 2001, a seminal book, The Handbook of Religion and Health, was published,[8] covering more than 1200 studies and 400 research reviews. A sixty to eighty per cent correlation between religion or spirituality and better health was found in the areas of prevention, recovery and coping ability in a wide range of conditions, including high blood pressure, cerebro-vascular disease, heart disease (including substantially increased survival in the elderly after heart surgery), immune system dysfunction (increased survival time in AIDS patients), improved coping with cancer (in one study, 93% of cancer patients said that their religious beliefs helped sustain their hopes), in living with pain and disability, and smoking prevention. Not least, there is a striking correlation with longevity. Attending religious services more than once weekly increases the lifespan by an average of 7 years for whites and 14 years for African Americans.[9]

These many studies have been based on standard research methods, using controlled trials and statistical data analysis. A good example has been the effect of intercessory prayer on patients in intensive care units, a double-blind trial that yielded a statistically significant result (the prayed-for group of patients recovered with fewer complications).[10,11]

Psychoneuroimmunology

We are now learning much more about how the healing process may be influenced by spirituality. For example, research has shown that stress down-regulates immune function, whereas a person's religious/spiritual beliefs will protect their immune functioning. Recent laboratory findings include:

- A rise in salivary IgA levels (a marker of immune function) in students watching a film of Mother Teresa, compared with students watching a war film [12]
- The levels of serum IL-6 (interleukin-6) in subjects regularly attending religious services is nearly 50% lower than in non-attendees. (IL-6 is a powerful mediator of the inflammatory response) [13]
- In a study on HIV positive gay men, spiritual and religious practices and beliefs were associated with higher CD4+ counts (lymphocytes - specific white cells - active in mounting the immune response) than in the control group. On the other hand, high stress levels increase the progression of the disease fourfold [14]
- In a study of women with breast cancer, the importance of religious or spiritual expression correlated positively with natural killer cell numbers (active against tumours and infective microbes), T-helper cell counts and total lymphocyte activity [15]

Spirituality and Mental Health

In the mental health field, where stress is common to every kind of breakdown, the extraordinary protective effects of religion and spirituality are now just beginning to be recognised.[16] For example:

- *Depression.* Overall, some 25% of women and 12% of men suffer major depressive disorder during their lifetime. But people with a spiritual or religious affiliation are up to 40% less likely to get depressed than those who don't have such an affiliation. And when they do get depressed, they recover faster. Where psychotherapy is offered, those receiving religiously orientated therapy sensitive to their religious beliefs score best on post-treatment measures [17]
- *Depression among the medically seriously ill*. Depression affects up to 35% of this group of patients. One study using multidimensional measures showed that for every 10-point increase in the intrinsic religion score, there was a 70% increase in the speed of remission from depression.[18] Another study showed that the more severe the disability, the stronger the protective effect of religious commitment [19]
- *Suicide.* Adults aged over 50 who have never participated in religious activities are four times more likely to commit suicide than those who do. This holds true after having adjusted for other variables.[20] Similarly, religious commitment among teenagers significantly reduces the risk of suicide [21]
- *Substance Abuse*. Religious/spiritual commitment correlates with lower levels of substance abuse. The risk of alcohol dependency is 60% greater when there is no religious affiliation.[22] In one study of opiate withdrawal, 45% of participants in a religiously orientated programme remained drug-free at one year compared with 5% in a non-religious treatment programme.[23] Concerning alcohol abuse, those who participate in AA, which is spiritually orientated and invokes the help of a Higher Power, are most likely to remain abstinent after inpatient or outpatient treatment.[24]

Studies such as these surely tell us that there is far more to mental illness than the biological sciences can ever explain.

Psychiatry and Society

The problem for psychiatry is twofold. Firstly, psychiatry is still aiming to be a 'proper' science. Like its bedfellows, medicine and surgery, it wants to be proudly able to take its place among equals. (This has nothing to do with the genuine value of recent advances in brain neuroscience; it has everything to do with human behaviour). Consequently, the door is wide open to the pharmaceutical industry, which idealises the neurochemical model of illness. Massive profit is to be made from medication which is begun in young adulthood in a population that is long lived, for perhaps another fifty years, and which will 'keep on taking the tablets'. Where, on the other hand, is the money to be made

out of purely psychological, or even more so, spiritual, aspects of health care? The short answer is that there is none.

These are the surface manifestations of the cultural divide I referred to at the beginning – that we have grown up in a world in which nothing is sacred; there is no reverence for life, or death, and with scant regard for the 'mysterium tremendum'. It would seem that more and more people get sick – in just the first five years of Prozac coming on the market, over 10 million prescriptions were handed out. [25] Is this a symptom of the materialist culture of our post-modern world?

Secondly, psychiatry has reason to be even more reluctant than ordinary investigative science to enquire into the 'paranormal' – for spiritual revelations frequently have such characteristics. A great deal of psychiatry has depended on agreeing what is 'normal' and then evaluating in what way, and how far, the mindset of any one individual differs from the consensus view. When a person deviates sufficiently from that norm, it is called psychopathology, meaning disease of the mind.

It follows that the practice of psychiatry, more than any other branch of medicine, is dependant on social and cultural attitudes. Who is to say how much suffering is a meaningful part of life's journey - like the grit in the oyster that becomes the pearl - and when does it go too far? Making judgments about what is 'reality' and what are delusional beliefs can be life saving. A person tormented to the point of suicide by voices telling her that she is evil needs urgent treatment that may require medication. Yet not to support her in coming to an understanding of what she has been struggling with would be to deny her spiritual reality.

But how careful we must be! Jesus Christ would very probably now be diagnosed as suffering from delusions of grandeur and what would we make today of the revelations of the Saints and prophets, or of the visions of Julian of Norwich, for example? There are a whole host of things that fly in the face of consensus reality - precognitions, deathbed visions and out-of-body and near-death experiences, telepathy, remote viewing and influencing, past-life and between-life regressions, Spiritism, channelling and communications from the deceased.[26,3,27] And what indeed of the burgeoning research into the 'paranormal' that is now strongly confirming psychokinesis, presentiment and distance healing, to name but a few? [28,29]

Psychiatric Diagnosis and the Spiritual Emergency

When it comes to psychiatric training, the conservatism of medical education ensures that the blinkers go on early. Further, to validate phenomena that lie way outside of consensus reality would only complicate carrying out an already difficult job.

Sometimes we can make a clear-cut distinction, for instance, between the medium who dedicates himself or herself to helping others through making contact with the deceased, and someone whose life is blighted by the intrusion of voices that interfere with ordinary thinking. The phenomenology of the hallucinations, to use that term, may be identical, such as hearing voices coming

from ‘outside’ in the absence of any evident stimulus. But the significance for health as opposed to illness is entirely different. [30,31]

Psychiatry has begun to acknowledge this in a small way. In ICD -10, the diagnostic manual used in the UK, there is now an entry for trance and possession disorders (F44.3).[32] These are classified as disorders in which *‘there is a temporary loss of both the sense of personal identity and full awareness of the surroundings; in some instances the individual acts as if taken over by another personality, spirit, deity or ‘force’.’*

Most importantly, ICD -10 goes on to say that ‘*only trance disorders that are involuntary or unwanted, and which intrude into ordinary activities by occurring outside (or being a prolongation of) religious or other culturally accepted situations*’ should be included here.

In the equivalent American manual, DSM - IV,[33] there is a new category entitled ‘Religious or Spiritual Problem’. This category does not imply illness but is drawing long overdue attention to the patients’ religious or spiritual beliefs.

However, there is not infrequently the problem that mental illness and paranormal experiences can occur together, making it very hard to tease apart one from the other.

How then, to distinguish between the spiritual emergency and making a psychiatric diagnosis? One way of looking at this is whether the experiences being reported can be understood as holding an existential truth that a person may need to face; in other words, do they bring the chance of a new level of integration. This may not be immediately evident, in that any life crisis is first and foremost felt as shattering. Yet, as the old saying goes, you can’t make an omelette without breaking eggs! The aim must always be to find meaning and purpose in the crisis, with the chance of moving towards wholeness of being; and this cannot happen unless the right therapeutic skills are in place.

What is essential is that psychiatrists should be encouraged to explore, debate and share their uncertainties in this area. The danger is in getting locked in to a narrow and rigid classification of disorders that disregards the humanity of the individual.

Future Directions

In the UK, we have many challenges ahead. I have barely touched on the question of how to differentiate between spiritual emergency and mental illness and we need to gain a much better understanding of this whole area. There is also the important question of how best to link with chaplaincy and spiritual/religious support networks, so often marginalized by psychiatry.[34,35,36]

Then there is the urgent need for a more holistic approach to mental health care, sadly lacking at present. The World Psychiatric Association and the World Health Organisation have both called for more attention to be given to spirituality and religious beliefs, yet in the clinical setting, religion is often little more than a tick in the box.

Exploring spiritual/religious beliefs and values in the clinical setting is not difficult. For instance: [16,37]

- What is the patient's spiritual/religious background?
- Are spiritual/religious beliefs supportive and positive, or anxiety provoking and punitive?
- What role did spirituality/religion play in childhood, and how does the patient feel about that now?
- What role does spirituality/religion play now in the patient's life?
- Is religion/spirituality drawn upon to cope with stress? In what ways?
- Is the patient a member of any religious community? Is it supportive?
- What is the patient's relationship with their clergy like?
- Are there any spiritual/religious issues the patient would like to discuss in therapy?
- Do the patient's spiritual/religious beliefs influence the type of therapy he or she would be most comfortable with?
- Do those beliefs influence how the person feels about taking medication?

The Spirituality and Psychiatry Special Interest Group is urging the Royal College to include taking the spiritual history alongside all other areas of enquiry. Educational goals and objectives include:

The historical perspective

The trainee should be able to demonstrate awareness of, and sensitivity to:

- The interface of spirituality/religion and psychiatric practice with reference to its historical development and current status

Spiritual aspects of clinical work and associated teaching

1) *The trainee should be able to demonstrate awareness of spiritual aspects of psychiatry arising from:*

- The need to find a sense of meaning and purpose in life
- The personal search for answers to deeper questions concerning birth, life and death
- The difference between spirituality and religion, and their inter-relatedness
- The relationship of spirituality to the development and expression of individual human values
- How spirituality informs concepts of good and evil

2) *The trainee should be able to demonstrate a working knowledge of:*

- Spiritual crises, meditation, prayer and altered states of consciousness, including Near Death Experiences
- The spiritual significance of anxiety, doubt, guilt and shame
- The spiritual importance of love, altruism and forgiveness, and their relation to mental health
- The influence of materialistic goals on personal identity and self-esteem
- The reciprocal relationship between culture and spiritual/religious beliefs and practices, and the consequences for psychiatric practice

- How to take a spiritual history from a patient
- How the presence or absence of spiritual/religious beliefs and practices in mental healthcare workers may influence clinical decision-making
- The role in clinical management of spiritual/religious support networks, including chaplaincy and pastoral care departments as well as those in the community

Research

The trainee should be able to demonstrate familiarity with:

- The application of both quantitative and qualitative research to the field of spirituality and psychiatric practice
- The findings of epidemiological studies relating spirituality to mental health variables
- The introduction of spiritual values in the design and execution of research
- Validated instruments for measuring spiritual and religious beliefs
- The contribution of research to understanding the neuro-physiology and efficacy of prayer, meditation, forgiveness and love

Spiritual attitudes and values

The trainee should be able to demonstrate:

- Awareness that good medical practice is founded on values which include discernment, compassion, generosity, tolerance, patience, honesty, humility and wisdom
- Awareness of how his/her own value systems may impact on others
- Sensitivity to, and tolerance of, the value systems of others
- An understanding of the concept of spiritual development as part of personal growth

Clinical skills based on spiritual values

The trainee should be able to demonstrate competence in:

- Being able to stay mentally focused in the present, remaining alert and attentive with equanimity
- Developing the capacity to witness and endure distress while sustaining an attitude of hope
- The recognition of his/her own counter-transference responses to spiritual disclosures
- Honest self-appraisal, in the interests of continuing personal development
- Maintaining personal well-being in the interests of patient care.

Implications for mental health professionals

The task for the carer is, of course, not to assert the supremacy of his or her own worldview, but to help the patient find a way to live in, and with, the world, even when the patient's beliefs and values might appear to outsiders to be highly idiosyncratic. Such beliefs, sometimes classified as delusions, can none the less be explored in terms of hopes and fears that have a universality of

meaning. Why are we here, what about the problem of good and evil, why must we suffer, what happens when we die? Such fundamental questions tend to get pushed aside by the pressures of everyday life. But when someone has a breakdown, these questions loom large and if the psychiatrist is not afraid to enter into the dialogue, a deep contact is made. This can be crucial if a breakdown is to have the chance of turning into a breakthrough.

Spiritual awareness needs to be a cornerstone of psychiatry. While input from the chaplaincy can be invaluable, there are times when it falls to the doctor, nurse or carer to respond and we know from service user-led research that this is being asked of us.[38]

Putting spirituality into psychiatry means being open, interested and asking the relevant questions. It does not mean having to provide answers or putting on a show of wisdom. It does means being able to say 'I don't have the answer, but I do want to know what is important to you, so let's take some time to look at this together'. It does mean respecting and valuing a person's beliefs and recognising how those beliefs can play a crucial part in recovering a sense of wholeness of being and health in life.

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