‘Why Psychiatry Needs Spirituality’

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The suggestion that psychiatry might need spirituality is an unusual one for two reasons [i]. It is clear that psychiatrists as a professional group are not particularly religiously inclined [ii]. Neeleman and Persaud suggest that somewhere in the region of 67% of British psychiatrists do not believe in God [iii]. Other studies have confirmed a similar lack of interest in the spiritual dimension [iv]. The reasons for this omission are complex [v]. Suffice here to say that in terms of self-identity, training and practice, spirituality does not have a high profile within psychiatry.

The suggestion that psychiatry needs spirituality also appears dissonant in relation to the current decline in religion within the UK and Europe. It is clear that traditional religions are in a sharp decline and have been since the late 1950’s. Surely this would indicate that spirituality is becoming *less* rather than more important? Why would psychiatry *need* spirituality within a context that is ‘obviously’ in spiritual decline.

The increasing interest in spirituality

However, a closer examination of the spiritual landscape within the United Kingdom throws up some interesting observations. In line with much of Western Europe [vi] there is a significant decrease in adherence to traditional, formal institutional religion. The decreasing number of people regularly attending places of worship evidences this. [vii] However, whilst traditional religion *appears* to be in decline, (a closer examination shows that Europe is an exceptional case [viii] and even within that context there is wide variation [ix]), there is a corresponding *increase* in the number of people expressing the importance of spirituality for their lives and claiming to have spiritual experiences and beliefs. Spirituality appears to have migrated from the overtly religious towards a more individualistic and subjective quest that has no necessity for formal structures.[x] People now want to *believe* in things spiritual, but no longer wish to *belong* to traditional religious institutions.[xi] Spirituality remains of importance to large numbers of people.

What do we mean by ‘spirituality?’

In assessing the significance of the spirituality, it is important to distinguish between ‘religiosity’ and ‘spirituality’. *Religiosity* is defined as participation in the particular beliefs, rituals, and activities of traditional religion. It can serve as a nurturer or channel for spirituality, but is not synonymous with it. *Spirituality* is more basic than religiosity. It is a subjective experience that exists both within and outside of traditional religious systems. Spirituality relates to the way in which people understand and live their lives in view of their sense of ultimate meaning and value. It includes the need to find satisfactory answers to ultimate questions about the meaning of life, illness and death. It can be seen as comprising elements of *meaning, purpose, value, hope, love* and for some people, *a connection to a higher power* or something greater than self. Perceived in this way, spirituality is not simply found in ‘religious patients’, but may be present in all patients.

Why God won't go away

This raises an interesting question: in a secularised, materialistic culture, why is it that people seem determined to retain spirituality and give importance to it in their lives? Andrew Newberg and his colleagues in their book *Why God Won't Go Away* [xii] investigates this question from his perspective as a neurologist. Newberg engages in a series of neurological investigations into the impact of meditation on Buddhist monks and Franciscan nuns. Newberg's findings indicate that human beings are hard wired for religious and spiritual experience for evolutionary purposes. He argues that there is a specific area of the brain which is designed to receive religious and spiritual experiences, in the same way as there is an area of the brain designed to receive sound, vision and so forth. The field has come to be known as *Neurotheology* and the area of the brain identified as the spiritual powerhouse has popularly come to be known as the *G spot!* The God spot.

Newberg's method was to link the monks and nuns to a SPECT camera (single photon emission computed tomography), and observe what changes occurred in the function of the brain when the person entered into a meditative state. Newberg and his colleagues noted that when a person entered into a deep meditative trance, a small lump of grey matter in the top rear section of the brain (the posterior superior parietal lobe) began to show unusual activity. This part of the brain functions to orient an individual in physical space. It 'keeps track of which end is up, helps us judge angles and distances, and allows us to negotiate safely the dangerous physical landscape around us. To perform this crucial function, it must generate a clear, consistent cognition of the physical limitations of the self'. [xiii] The PSPL is the part of the brain that maps out and distinguishes what is me from what is not me. What Newberg discovered was that within a meditative trance this part of the brain began to close down. Consequently the meditator experiences feelings of merging with the world around them as the boundaries between 'me' and 'not me' broke down. For the Buddhists this was experienced as a general merging with the universe; for the nuns it was reported as a feeling of closeness to and merging with God. From this Newberg develops a theory that spirituality is a biological, inbuilt dimension of human beings which has been retained for evolutionary purposes.

Now, one might argue that this perspective is reductionistic; the danger being that people assume that God, religion and spirituality are *nothing but* the products of neurology. But this need not be the case. Depending on your starting position you might interpret Newberg's findings accordingly. If you don't believe in God you will be comfortable with the evolutionary explanation for the retention of spirituality within human development. If you are religious, then it will be clear that (whatever its developmental origins), the neurological receptor of spirituality is God-given; another way of communicating with God comparable with other areas of the brain that relate to communication with the Divine. (reason, intellect, the ability to read Scriptures etc.) These two interpretations need not be exclusive. My colleague David Hay has pointed out that even the evolutionary explanation does not rule out the reality of God. [xiv] Within evolutionary theory things happen for a reason. We have ears because there is something to hear, eyes because there is something to see and a structure relating to spiritual experience because there is something to experience.

Spirituality as a human universal: Relational consciousness

In line with some of Newberg's thinking, but differing significantly from it, is David Hay's work on the biology of God. In his 1966 Gifford Lectures given in Aberdeen University, biologist Alister Hardy put forward the thesis that religious or spiritual awareness has evolved in the human species because it is necessary for survival. Over many years Hay has developed Hardy's work and has put forward some convincing evidence for there being a biological basis for spiritual experience. [xv] Here we will examine one dimension of Hay's thinking as it relates to the spirituality of children. In his book *The Spirit of the Child,* Hay presents some research that he did on the spirituality of children. He proposes that children are naturally spiritual; that they have an inherent sense of awe, wonder and acceptance of things beyond their understanding. This inherent awareness he describes as *relational consciousness.* Relational consciousness is a form of consciousness characterised by the fact that it is always relational: self/other people, self/environment, self/God. It is what makes spirituality possible and in a certain sense 'is' spirituality. Phenomenologically it is experienced as the shortening of the psychological distance between self and the rest of reality; a dissolving of the boundaries, that at the limit becomes the loss of distinction between self and other of the mystic. [xvi] From Hay's perspective this is the source of the experiential basis of religion, seen as a social construction in response to spiritual experience.

However, whilst spirituality is relational and naturally inherent within the experiences of children, when they enter the educational system they are *de-spiritualised*. They are taught to think logically and rationally and to downgrade or even exclude the pre-school spiritual experiences that were so formative of their early perceptions of the world. Hay identifies this spiritual repression with certain forms of frustration and aggression encountered by children in their teens.

If we accept Newberg, Hardy and Hay's hypotheses, then two important things emerge. Firstly, in opposition to post-Enlightenment ideas of the social construction of religion (cf. Feuerbach and the subsequent development of his ideas by Marx and Freud), if these researchers are correct, it is actually *secularisation* that is socially constructed in opposition to the natural human experience of spirituality. [xvii] Whilst people who suggest the significance of spirituality for mental health care are often accused of imposing alien values on vulnerable people, if the evidence presented thus far is correct, then *not* to address the spiritual dimensions of patient's experiences is to risk imposing false, secular values on vulnerable people.

Secondly, if this mode of thinking is correct, then it is not only overtly religious patients that will be experiencing spirituality and spiritual issues, but *all* of the patients whom psychiatrists encounter. If this is so, psychiatrists at least need to be open to the possibility that spirituality may be significant for certain patients and that that significance may have clinical utilility.

Religion and health – the known research

A final dimension of the growing evidence base that suggests psychiatrists should take spirituality seriously relates to the developing research base which indicates a positive correlation between spirituality and

mental health. In the light of the discussion on the biological roots of spirituality it is probably not surprising that we can discover some interesting correlations between spirituality and mental health [xviii]. The extensive research work of people such as Harold Koenig [xix] and David Larson [xx] is indicative of there being a positive association between religion, spirituality and mental health [xxi].[xxii] The data from this field of research is suggestive (although not conclusive) that there may be certain positive associations between religious and spiritual observance and mental and physical well-being. Religion and spirituality have been shown to be beneficial on a number of levels and in relation to a wide variety of conditions. Health benefits include:

- Extended life expectancy.
- Lower blood pressure.
- Lower rates of death from coronary artery disease.
- Reduction in myocardial infarction.
- Increased success in heart transplants.
- Reduced serum cholesterol levels.
- Reduced levels of pain in cancer sufferers.
- Reduced mortality among those who attend church and worship services.
- Increased longevity among the elderly.
- Protection against depression and anxiety.
- Reduced mortality after cardiac surgery. [xxiii]

Of particular interest from the perspective of psychiatry is the ability of spirituality to reframe mental health problems, at least potentially, in positive ways. On the basis of current knowledge we might consider that religious and spiritual beliefs may affect patient's well being in the following ways:

- Enhances coping by offering such things as hope, value, meaning and purpose.
- Facilitates social integration and support by linking religious patients with specific forms of caring communities.
- Provides systems of meaning and existential coherence.
- Establishes a perceived relationship with a divine other, i.e. persons can extend their circle of social support by drawing in religious and spiritual figures.
- Promotes participation in specific patterns of religious organisation and lifestyle which may offer support and protection from, for example, anxiety and depression.

This reframing is not always positive, but it is certainly not always negative.

Understanding the experience of mental illness

It is easy to forget that mental illness is a deeply personal and meaningful event within a person's life before it becomes a diagnosis. Diagnoses give a formal structure to personal experience but they do not (or should not) define the nature of that experience. Mental illness brings about changes in people's lives; events which often challenge people to think about certain aspects of their lives quite differently. Sometimes these changes are

pathological, at other times they are transformative and deeply spiritual [xxiv]. The danger is that if psychiatrists are not aware of the spiritual dimensions of mental health problems, the transformative can easily become subsumed to the pathological with detrimental effects on patient care. When this happens we run the risk of creating despiritualising institutions and modes of care in line with Hay's criticism of the despiritualising influence of our educational system.

Spirituality is important in that it provides belief structures and modes of coping within which people can make sense of their lives, explain and cope with their illness experiences and find and maintain a sense of hope, inner harmony and peacefulness in the midst of the existential challenges illness inevitably brings. Current research indicates that this type of reframing may have clinical utility. To practice in ways that assume such experiences to be unimportant, inevitably pathological or somehow secondary within the process of mental healthcare is to misunderstand in a quite fundamental way the nature and experience of mental illness and the significance of the person-as-person as opposed to the person-as-diagnosis.

The occlusion of spirituality

In the light of the evidence put forward in the first half of this paper, one might wonder why it is that spirituality has such a low profile within the practice and philosophy of psychiatry. An immediate response might be to point out the dangers of pathological spirituality arguing that it is far too dangerous to take spirituality into the clinical process as it opens up patients to powerful ideologies that may be dangerous. This position of course contains truth. Any powerful belief system has the potential for good and bad. However, to paternalistically decide that spirituality is bad for people without firm empirical evidence and without taking into consideration the fact that patient's might disagree [xxv], is to close down a potential source of healing without taking seriously its implications for good practice. The connection between religion, spirituality and pathology is not at all clear. It is certainly the case that people encountering severe mental health problems may utilise religious language and concepts to express their pain. However, if, as I have suggested, spirituality relates to the values, beliefs and understandings which are core and fundamental to a persons' perception of the world and themselves within it, it is not at all surprising that they will use that same language and those same concepts to express the experiences they are going through. Expressing pathology through religious language does not necessarily indicate a causal connection [xxvi]. Avoiding religious and spiritual language does not necessarily bring healing and offer respect for the client's well-being. Indeed, as I have suggested, a lack of a willingness to engage with spirituality might end up being detrimental to care. Despite the potential problematic issues that may arise, the evidence would suggest that psychiatrists, at least, need to be aware of the potential significance of this dimension of patient's experience even when it is manifested in the context of severe mental health problems.

Why does psychiatry struggle to see the significance of spirituality?

Yet, despite the growing evidence base, there remains a good deal of resistance even to explore the types of issues we have looked at in this paper.

Why might this be? In order to begin to answer this question we need to think about the significance of *worldviews.* Our worldviews make up our perspective on and understanding of the world. They contain and define the structures of normality and the general assumptions about the nature of that which we assume to be reality. Importantly, *worldviews shape and place boundaries on what we see in the world.* Worldviews are not real in a strictly ontological sense, they are things that cultures create. Nevertheless, they *are* real for those who accept them. Worldviews are temporary and are constantly changing. We no longer, for example, believe that the earth is flat or that the sun revolves around the earth. But we did at a particular moment in history; then, it was considered to be a scientific fact. Presumably much of the knowledge we currently have now will also be shown to be 'false' or at least different from our current understanding at some point in the future. Worldviews are thus temporary and transient, but nonetheless tremendously powerful in terms of their ability to shape the world. At any given point there are particular dominant ideas that shape worldviews and the thinking and understandings of those who accept them as reality. Within our own culture, biomedicine and its accompanying ideology has become a powerful shaper of our worldview and the ways in which we assume we should respond to health, disease and healing. For most of us it is within the worldview created by biomedicine that our interpretations of mental illness take place. Colin Samson argues that our current way of doing medicine emerged as a result of the developments that emerged during the Enlightenment.

> Enlightenment medicine reflected a confidence in scientific methods of observation and experimentation to *control* nature and *intervene* to correct ailments that seemed to cut short life…The approach to sickness advocated by the medical profession has now become almost a monopoly by virtue of its legitimisation by the state in all Western countries as well as other societies [xxvii].

The concurrent movement towards prioritisng science and the scientific method within our interpretations of mental illness has resulted in a redefinition of the issues that once preoccupied philosophers. The questions:

What is human nature?
How is happiness achieved?
What is a good life?

have been restated as

What is normal?
How can it be measured?
What conclusions are generalisable ? [xxviii]

Within this scientistic worldview the unique and particular aspects of human beings become secondary to the generalisable and universal aspects. Spiritual interpretations of illness experience sits easily within the first set of questions, but becomes most uncomfortable when faced with the second.

What is interesting about the approach of the medical model is that, in principle at least, there is no need for the presence of a person. The individual as a meaningful interpretative being with goals, dreams, expectations and hopes is substituted for an understanding of persons as machines or at least as machine like. Within this understanding, good healers are perceived as effective mechanics able to utilise scientific technology to bring the body back to a state of health and well-being. So powerful is this way of perceiving and responding to health and illness that it is almost impossible to think of mental health without thinking about psychiatry and pathology. And yet, as our exploration of spirituality has shown, there is much more to mental illness than diagnosis and pathology. The point is not that biomedicine is wrong or that we should somehow do away with it. The problem being highlighted here is the way in which biomedicine has colonized our healthcare worldview and shaped our expectations in such a way as to blind us to other hidden and very important aspects of the experience of being ill; other interpretations which are equally true and which may be crucial to the practice of spiritually oriented mental health care. What is required is not a rejection of science, but an *expanded* science which includes issues of value, meaning and transcendence. The problem is that, for the most part we only see what our worldview and our assumptions allow us to see. If we use the example of this well-known optical illusion the point will become clearer.

Do you see an old woman or a young woman? Psychologists inform us that if we have a propensity towards older women that is what you will see. Similarly, if we have a propensity towards younger women, that is what we will see! Eventually we will see both, but most people don't until the second one is pointed out to them. *People in general tend to see what they expect to see or at least, what they are primed to see.* I want to suggest that the same principle is at work in the ways in which we understand health and healing. Because the medicalised perspective is so powerful within our culture it is almost impossible for us to see disease and healing in any other way until it is pointed out to us. When it is pointed out to us we begin to see things differently. When we see things differently we begin to act differently.

Rediscovering the 'forgotten' dimension

One way of beginning to open our worldviews to an expanded science is by focusing on the area of spirituality. The biomedical view informs us that science is the only story that can be told about source health and illness. A focus on a spiritual perspective reminds us that much of the knowledge we gain and live by is not 'scientific', insofar as it is not generalisable or replicable but unique and non-repeatable. Many of our patient's most profound and important illness experiences are not related to the assumed boundaries of their diagnosis. In closing let me offer an example which will help to illustrate the point.

In his book *The Man Who Mistook His Wife for a* Hat [xxix], neurologist Oliver Sacks relates the story of a man, Jimmy, whose memory had been destroyed by Korsakov's syndrome. Korsakov's syndrome is a specific form of dementia which is the product of long-term alcohol abuse. It leads to irreversible degeneration of the brain. One of its central features is profound memory loss. The loss is so profound that sufferers become people without a past or a future, interminably trapped in an eternal present and bound permanently within one period of time. People with this form of mental health problem are in a very real sense lost and unable to establish roots. Sacks, from his position as a neurologist, assumed the truth of the medical narrative within which the Korsokov's was presumed to have 'de-souled' Jimmy. However, while Sacks conceived of Jimmy as being in a sense absent from mainstream humanity, those close to Jimmy saw something else. Sacks recalls how one of the nurses drew his attention to a dimension of Jimmy's experience which had been hidden from Sack's medical gaze. 'Watch Jimmy in chapel and judge for yourself' said one of the nurses.

> I did, and I was moved, profoundly moved and impressed, because I saw here an intensity and steadfastness of attention and concentration that I had never seen before in him or conceived him capable of.…Fully, intensely, quietly, in the quietude of absolute concentration and attention, he entered and partook of the Holy Communion. He was wholly held, absorbed, by a feeling. There was no forgetting, no Korsakov's then, nor did it seem possible or imaginable that there should be - clearly Jimmy found himself, found continuity and reality, in the absoluteness of spiritual attention and act.

From Sack's position as a neurologist, Jimmy's was a narrative of pathology, lost personhood and presumed hopelessness. Yet, when he was 'forced' to listen to the second narrative and to explore Jimmy's lived spiritual experience, his perspective was transformed. His revised understanding, resurrected the person behind Jimmy's condition and opened up new possibilities for care and understanding that reached beyond the boundaries of the biomedical model and into the mystery which is human life.

For Jimmy, his spiritual encounter with the Holy provided him with an anchor and a sense of self that was otherwise missing from his life. His experience seemed to locate him within a narrative that gave him meaning, purpose and a sense of self which transcended the limitations of his fading personal narrative. In the realm of the spiritual, Jimmy seemed to function in ways that moved beyond the expectations of the medical professions and

offered him relief and purpose in the midst of a world of profound meaninglessness.

This story provides a useful example of the type of the way in which an acknowledgement of the significance of spirituality can radically reframe a situation. Sacks' professional worldview primed him to see only pathology in Jimmy. The person was not part of the equation. When he and Jimmy came together within a professional context, there was a vital aspect missing from Sack's interpretation of what was going on which prevented Sack's from seeing the whole of the situation. That missing dimension was Jimmy's spirituality. It was impossible for Sacks to accurately interpret the situations until he recognized the significance of spirituality for Jimmy's horizon [xxx].

Conclusion

In conclusion, it would appear that psychiatry needs spirituality if it is to provide a service which is person centred and meaningfully holistic. Not everyone will agree with the arguments presented in this article. That is as it should be. However, the fact that many readers will be experienced practitioners and will never have been exposed to this way of thinking about spirituality is indicative of a lack in the ways in which psychiatrists are trained and the types of information that is currently being made available to them. Psychiatry needs to wrestle carefully and thoughtfully with the issues raised by spirituality and in the process of doing this, begin to recognise that patients may expect them to know and to understand more than they assume they should.

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[i] This paper was originally presented to the Royal College of Psychiatrists AGM in Edinburgh 22/6/05. It appears here in a slightly revised form.

[ii] Crossley, David. (1995) 'Religious experience within mental illness: opening the door on research.' *British Journal of Psychiatry*. 166(3) March:284–286.

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[v] Swinton, J. (2001) *Spirituality and Mental Health Care: Rediscovering a "forgotten" dimension* London: Jessica Kingsley Publishers

[vi] Davie, G. (1994)., *Religion in Britain since 1945: believing without belonging*, Oxford; Cambridge, Mass: Blackwell

[vii] Scottish Church Census 2002 http://www.scottishchristian.com/features/0305census01.shtml It should be pointed out that it is only certain forms of traditional religion that are in decline. Evangelical Christianity, for example, seems to be on the increase rather than in decline. Likewise other traditional religions such as Islam are also increasing. It would appear to be the form rather than the context of traditional religion that is failing to resonate with contemporary postmodern society.

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[ix] Casanova, J. (1994). *Public Religions in the Modern World*, Chicago and London: Chicago University Press; also, Borowik, I. & Tomka, M. (eds.). (2001).*Religion and Social Change in Post-Communist Europe*, Krakow: Zaklad Wydowniczy

[x] Heelas, P. & Woodhead, L. (2005) *The Spiritual Revolution. Why Religion is Giving Way to Spirituality* Oxford, UK and Malden, USA: Blackwell,

[xi] Davie, op. cit.
[xii] Newberg, A., d'Aquili, E. & Rause, V. (2001). *Why God Won't Go Away: Brain Science and the Biology of Belief*, New York: Ballantine Books.
[xiii] Ibid, pp. 4 -5
[xiv] See for example, 'The biological basis of spiritual awareness', in Ursula King (ed.) *Spirituality and Society in the New Millennium* , Sussex Academic Press, 2001, 124-135
[xv] See, for example, *Exploring Inner Space: Scientists and Religious Experience*, London: Penguin Books, 1982; 'The biology of God': What is the current status of Hardy's hypothesis?' *International Journal for the Psychology of Religion*, 4(1), 1994, 1-23; *The Spirit of the Child*, London: HarperCollins, 1998; *Something There: the Biology of the Human Spirit*, Darton, Longman & Todd (forthcoming).
[xvi] Hay, personal communication.
[xvii] See, *The Spirit of the Child*,op. cit. Chapter 2, 'The social destruction of spirituality'.
[xviii] Swinton ibid.
[xix] Koenig, Harold G. (ed) (1998) *Handbook of Religion and Mental Health*. San Diego, Academic P.
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[xxi] Koenig H McCullough M Larson D (2001) *Handbook of Religion and Health* Oxford University Press
[xxii] Larson D B Swyers J P McCullough M (1997) Scientific Research on Spirituality and Health: a consensus report. National Institute for Healthcare research
[xxiii] Ibid
[xxiv]Luckoff D., Lu, F., and Turner, R. (1998). From spiritual emergency to spiritual problem: the transpersonal roots of the new DSM IV category. Journal of Humanistic Psychology, 38(2), 21-51.
[xxv]Nicholls, Vicki. (Ed) *Taken Seriously: The Somerset Spirituality Project.* London:Mental Health Foundation.
[xxvi]Williams, Richard., and Faulconer, James E. (1994) 'religion and mental health: a hermeneutical reconsideration.' *Review of Religious Research*. 35, 4. June:335–349.
[xxvii]Samson, C. (1999) Health Studies: A Multidisciplinary Reader London: Blackwell
[xxviii]Nolan P. Crawford P. (1997) Towards a rhetoric of spirituality in mental health care. *Journal of Advanced Nursing*. 26(2) Aug:289-94.
[xxix]Sacks, Oliver. (1968) *The Man Who Mistook His Wife For A Hat*. Harper Collins.
[xxx] The case of dementia of course offers some interesting challenges to the theories of Newberg and Hay. If spirituality has a neurological root, what happens if that piece of the brain is damaged or destroyed by dementia or other forms of neurological damage? Does this mean that a person ceases to be a spiritual being?