Spirituality and Psychotherapy

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'We live in succession, in division, in parts, in particles. Meantime within man is the soul of the whole; the wise silence; the universal beauty, to which every part and particle is equally related, the eternal ONE. And this deep power in which we exist and whose beatitude is all accessible to us, is not only self-sufficing and perfect in every hour, but the act of seeing and the thing seen, the seer and the spectacle, the subject and the object, are one. We see the world piece by piece, as the sun, the moon, the animal, the tree; but the whole, of which these are shining parts, is the soul.'
Ralph Waldo Emerson, 'The Over-soul', Ninth Essay (1841)

For many doctors, let alone the general public, the relationship of psychiatry to psychotherapy is a source of confusion. When is emotional disturbance a sign of a mental illness requiring drug treatment? When is it a problem able to be resolved through discussion and discovering how it arose? When is it a mixture of the two? And what is best done about it? People seeking help are often directed to psychiatrists, psychologists, psychotherapists, or counsellors without understanding either the range of options available to them or the rationale for consulting one rather than the other.

Spiritual concerns are regarded with even less clarity. Where there is a core religious problem and the person belongs to an established faith tradition, the priest, imam, rabbi or appropriate spiritual advisor is likely to become involved. However, for people who do not belong to a religious community or faith tradition there are no guidelines; the healthcare practitioner may or may not be personally interested in the patient's spiritual reality. In addition, psychiatrists working with a medical model of mental illness are likely to see spiritual issues as beyond their competence and many psychotherapists prefer to stick specifically to psychological objectives.

Yet some psychiatrists, and psychotherapists, do see the importance of addressing spiritual concerns, either because they intuitively recognise this to be an essential part of treating the 'whole' person or because they have undergone training in therapy that values this dimension of human life.

Mapping the territory

Psychiatry is a medical discipline specialising in the treatment of mental illness; as all Western medicine, it is founded on the concept of disease and its greatest ambition is nothing less than cure. Symptoms are the signs of disease and progress is directly measured by their alleviation.

Psychotherapy, too, aims to relieve mental distress, whether or not it occurs in the presence of diagnosable mental illness. Symptom reduction is an

important indicator of success, yet other subjective indices of improvement, less easily measured, such as becoming more aware of feelings, both one's own and other peoples', are also counted as important.

A working definition of spirituality has been given in Chapter 1 of this book (p. 4). It is one of many such attempts to address humankind's 'quest for understanding answers to ultimate questions about life, about meaning, and about relationship with the sacred or transcendent' (Koenig *et al.* 2001). It is described elsewhere as 'the essentially human, personal and interpersonal dimension, which integrates and transcends the cultural, religious, psychological, social and emotional aspects of the person or is more specifically concerned with 'soul' or 'spirit'' (http://www.rcpsych.ac.uk/spirit).

The wholeness of being with which spirituality is primarily concerned can be conceived in many ways. For some, it is to be found in the majesty of the physical universe; for some, it is the expression of love on which the future of every family, nation, even our planet depends, while others seek the presence of the Divine through meditation, worship and prayer.

In contrast, the prevailing reductionist culture of science deals not with the whole but with the part. A prime value, therefore, of introducing spirituality into this discussion is in offering a framework for relating the part to the whole, indeed, one in which the whole is greater than the sum of its parts.

One coin, two sides

Just over a hundred years ago, Albert Einstein showed in his famous special theory of relativity that mass and energy are exchangeable. Biological psychiatry, having taken the path of physicalist science, invests in the study of the physical brain. Psychotherapy, in contrast, is concerned with the mind, which has no mass. The psychiatrist who looks exclusively for physical explanations of mental illness, or the psychotherapist who dismisses the impact of brain chemistry, is each overlooking the other side of the coin by mistaking the part for the whole.

Einstein's vision was holistic and profoundly spiritual. Indeed, he was later to claim that 'every one who is seriously involved in the pursuit of science becomes convinced that a spirit is manifest in the laws of the Universe - a spirit vastly superior to that of man, and one in the face of which we with our modest powers must feel humble' (as quoted in Abrams & Primack, 2000: p. 154). Einstein's groundbreaking perspective shows us the whole coin, impressing on us the complementarity of brain and mind, how they exist conjointly, how each is irreducible and yet indispensable to the other. Einstein offers us a vision of integration, which is the essence of spirituality. Applied to our profession, it spans the divide within mental healthcare (Fig. 6.1).

Fig. 6.1 Spirit as the unifying principle

Spirit

Psychiatry ⟷ Psychotherapy
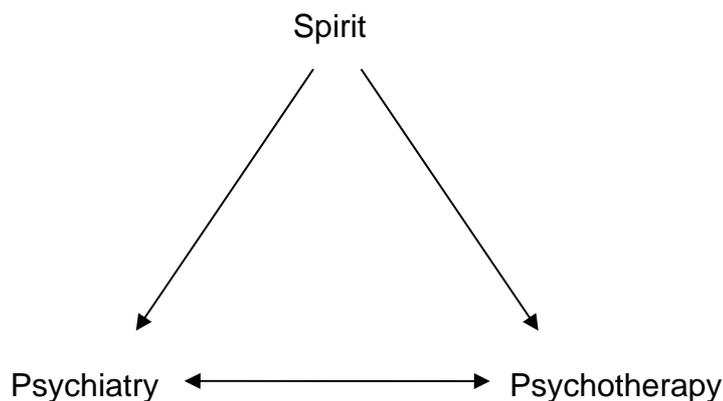
Why should such a holistic paradigm have been so tenaciously resisted? The answer lies in the human tendency to become emotionally attached to the culturally sanctioned vision of reality. Since Isaac Newton, the physicalist world view that matter is primary and mind secondary has prevailed. Yet current science, especially quantum mechanics, is making counter-intuitive demands on us that challenge common sense perception so that we may have to abandon the notion that matter comes before mind (consciousness) (Powell, 2002), and instead envisage both arising out of what astronomers call 'dark matter', now known to be swarming with unimaginable energies.

Psychiatry, like other applied sciences, has remained loyal to the physicalist worldview, but research into spirituality and mental health is widening the horizon (Larson & Larson, 2001; Larson *et al,* 2001). Instruments are being developed (King & Dein, 1998) that can provide a measure of the religious and spiritual dimension and there is strong outcome research on the value of specific spiritually-informed treatment approaches such as mindfulness-meditation (Kabat-Zinn *et al,* 1992; Kabat-Zinn 1995). Psychiatrists also need to be better informed about the science of parapsychology (Radin, 2006) and of the phenomenology of altered states of consciousness, so that they can be maximally discerning when patients are reporting anomalous events (Powell, 2004*a,b*).

Psychotherapy, too, is slowly waking up to the spiritual dimension, as seen in the increasing number of publications in the field (Bomford, 1999; Stein, 1999; MacKenna, 2002, 2004, 2005a,b, 2006, 2007; Schreurs, 2002; Field *et al,* 2005). Indeed, all psychological therapies have the potential to lead to spiritual development. Cognitive-behavioural approaches, which focus on changing components of behaviour, enhance a person's capacity to engage more fully with the richness of life. Of the analytical therapies, the Jungian approach has traditionally valued spiritual experience (Aziz, 1990; Singer, 1995; MacKenna, 2000; Casement & Tacey, 2006). However, within the Freudian approach, there are signs of increasing interest in spiritual and religious matters (Meissner, 1984; Symington, 1994; Klein, 2003; Black, 2006). Last, there is now a range of transpersonal therapies that seek directly to address the spiritual dimension (this will be discussed further).

The Place of Soul

We have highlighted the principle focus of psychiatry as identifying and treating the physical basis of mental illness, whereas psychotherapy addresses the psychopathology of mind. Further, we have used the term 'spirit' to denote that super-ordinate plane which embraces both the physical and mental worlds and which, in relation to mental healthcare, brings psychiatry and psychotherapy together in a unified field.

We will now consider the individual human being and in doing so, we shall adapt our paradigm (Fig. 6.1) by substituting 'body' for psychiatry, 'mind' for psychotherapy and 'soul' for spirit (Fig. 6.2).

Fig. 6.2 Soul as the unifying principle

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                    Soul



       Body  <------------------->  Mind
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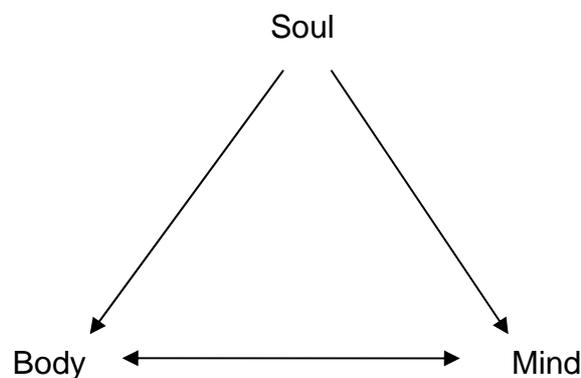
For most people the word 'soul' evokes a deep intuitive response. As we use it here, Soul describes the essence of each person, being a unique manifestation of the animating principle (Spirit) that enlivens each individual's psyche-soma. However, it reaches beyond that, for it also characterises the most elevated expression of human values, unselfish love, compassion and wisdom. Lastly, Soul conveys a sense of wholeness – of indivisibility, indestructibility and therefore, for many, eternal life.

In contrast to Soul, we are defining Mind more narrowly as the domain of the ego. Mind is identified with emotions, desires, thoughts and actions, indissolubly linked with the body and ultimately concerned with the survival of the organism.

Where the soul meets the mind there is invariably a conflict between the 'higher' and 'lower' self. (In Eastern metaphysics, according to the Vedic chakras, ego-driven love yields to selfless love) (Powell, 2003). Enabling the wisdom of the soul to enrich the limitations of the mind is the aim of all spiritual endeavour.

Psychosomatic research has shown that disturbances of the mind can have a profound impact on the body (Shoenberg, 2007). In contrast, studies in

psychoneuroimmunology show that religious and spiritual practices protect against down-regulation of the immune system, with important implications for infections and cancer (Koenig & Cohen, 2002), which we would understand as the influence of Soul on cell physiology.

What are the implications for clinical practice? The doctor-patient relationship is crucial in the success of any treatment being offered (Dixon & Sweeney, 2000). From the outset, the patient needs to feel he or she is being valued and treated as a human being - to be sympathetically received, listened to without judgement being passed and helped to make sense of what has gone wrong. The effect is to strengthen the 'the therapeutic alliance'[1], which in turn assists with relevant information-gathering, accurate diagnosis and ensuring the patient's full cooperation with the agreed treatment choices. All such therapeutic interventions, whether physical or psychological, will have the best possible effect when they are offered with sensitivity, care and concern, coming not from the self-interest of the ego but from the magnanimity of the soul.

One man's anguish

In this section we will explore the relationship of spirituality to mental health through the anguish of one particularly eloquent patient, the poet John Clare (1793–1864) (Bate, 2003). Clare was unusually well able to make the connection between his mental distress and his spiritual yearning. The poem, 'I AM', which he wrote while confined to St Andrew's County Lunatic Asylum, Northampton, reveals the suffering of all humanity, for the poet's art shows us that what is the most personal is also universal.

I AM

I AM – yet what I am, none cares or knows;
My friends forsake me like a memory lost:
I am the self-consumer of my woes -
They rise and vanish in oblivion's host
Like shadows in love–frenzied stifled throes -
And yet I am and live - like vapours tossed

The first two lines powerfully express Clare's sense of desolation and loneliness. 'I am the self-consumer of my woes' – tells us that Clare feels his misery to be beyond the reach of others. The phrase 'love–frenzied stifled throes' suggests there was once a time when his passions sought fulfilment in a relationship. Yet, now having lost contact with others, he is caught in a swirl of feelings that either parades before his eyes, or else he is painfully obliged

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[1] The therapeutic alliance is a term coined by Freud. The attributes needed in the therapist have been variously described as 'genuineness, empathy and non-possessive warmth' (Truax & Carkhuff, 1967), unconditional positive regard (Rogers, 1965) and 'the therapist's agapeistic attitude' (Lambert, 1981). (In the New Testament the Greek word agape is used for the love that seeks always to act in the best interest of the other).

to swallow. It is a measure, both of Clare's isolation and of his genius, that he can create a poetic form strong and supple enough to give such profound expression to his distress.

Apparently, there is no one in whom Clare can confide who might, in some measure, be able to help contain his impassioned anguish. The best he is able to do is to assert, if only briefly, the fact of his existence: 'I am and live' - like vapours tossed'. But this momentary achievement rapidly unravels:

> *Into the nothingness of scorn and noise,*
> *Into the living sea of waking dreams*
> *Where there is neither sense of life or joys,*
> *But the vast shipwreck of my life's esteems;*
> *Even the dearest that I love the best*
> *Are strange – nay, rather, stranger than the rest.*

Without a sufficient sense of self, Clare is reduced to 'scorn and noise,' a 'waking dream' in which there is only a sense of catastrophe (shipwreck) and estrangement from those he loved 'the best'.

Finding himself in this alienated state of mind, Clare's yearning for relationship is stripped to the most basic of mental structures. We see this in his deep longing for union with God – the desire to be cradled by the archetypes of the divine feminine, mother earth, and the divine masculine, father sky.

> *I long for scenes where man hath never trod,*
> *A place where woman never smiled or wept,*
> *There to abide with my Creator, God,*
> *And sleep as I in childhood sweetly slept:*
> *Untroubling and untroubled where I lie,*
> *The grass below – above, the vaulted sky.*

(Bate, 2004)

Given the prevalence of religious images in psychotic states of mind, from the psychiatric perspective it would be easy to discount Clare's spiritual *cri de coeur.* Equally, the psychotherapist might see in it merely the desire for regression to an infantile state.

We believe it is important neither to dismiss nor pathologise the patient's spirituality. From the spiritual perspective we would argue that Clare's archetypal imagery reveals the universal need for primary relatedness of self to other. Where to begin with Clare is only able to experience being in relation to himself - as the *I AM* - he then finds ontological security in his relationship with the Divine Other. The effect of this is to assuage his anxiety sufficiently for the poet to put down his pen.

Yet the suffering revealed in Clare's poem continued throughout the last 23 years of his life, all of which he spent in an asylum where he died on 20th May 1864. In such circumstances, should the psychiatrist stand by and condone suffering in the service of creativity? This ethical dilemma is all the greater

because so many creative people are wary of therapeutic 'interference', be it pharmaceutical or psychological, knowing instinctively that there is an intimate relationship between their pain and their capacity to create.

The problem for the clinician is therefore to know how and when to intervene, and to what effect: Should it be simply to relieve suffering? Is it to find a way to bring the person back into the fold of human relationships (sometimes kicking and screaming)? Or is the aim to enable the person to make sense of his or her suffering so that, while pain may not be alleviated, life can nevertheless be as rich and meaningful as possible?

In order to discover what the task may be, the psychiatrist has first to be able meaningfully to connect with the patient. How is this to be done, when someone, like Clare, has turned so emphatically away from the interpersonal world?

Finding a soul-centred response

All psychiatrists in the UK are obliged to make diagnoses in accordance with ICD-10 (World Health Organization, 1992) and detailed questioning is necessary to elucidate the signs and symptoms of the disorder. Unfortunately, this process of objectification can also have the unintended effect of denying the human reality of the individual with whom we are dealing. It is all too easy to end up by referring to someone as 'psychotic', no longer seen as a person but as a disturbed mental state.

John Clare speaks for many users of mental health services who feel that they have seen the doctor, but doubt whether the doctor has seen them: 'I AM – yet what I am, none cares or knows' - the feeling of being seen, yet not seen, only serving to intensify their suffering and confusion. Further, if the psychiatrist acts merely on the basis of social norms, he or she risks making value judgements that cannot do justice to each unique human soul, never more so than when dealing with eccentric, creative and unusual people. Engaging only at the psychological level of mind will not help Clare to feel his soul's need has been understood; a soul-to-soul connection is required to pave the way for his return to the human world.

The first step is to enter into Clare's inner world without imposing one's own value system and to identify the point of contact where Clare would feel that both his anguish and his yearning had been recognised. More than that, it requires being genuinely open to Clare's experience of being held in the arms of God.

To be asked 'How do you feel?', or 'What do you need?', addresses the concerns of the embodied ego. There is a place for this, of course, for the psychiatrist has a duty to see whether Clare's mental state is impoverished, for example, by a serious depression, which could be helped by medication (i.e. needs of the body). Further, the psychiatrist would be attempting to understand Clare's psychological defences against pain and loss, especially

since Clare is evidently disengaging from the world of human relationships (i.e. needs of the mind).

However, when the psychiatrist feels free to listen to his or her own heart, revealing their own humanity to Clare and venturing to speak from their own soul to ask of Clare 'What might your *soul* need?', Clare is likely to feel touched in his inmost being, for Soul speaks directly to Soul.

From this 'holy ground', like ripples widening in a pond, the enquiry can gently extend to what led Clare (in our example) to the extreme place where he must 'long for scenes where man hath never trod / A place where woman never smiled or wept'. This can be the start of a return journey to the world of minds, bodies and human relationships.

Freud re-visited

Let us compare this approach with how Sigmund Freud may have formulated the problem. Freud set great store by what he called the Reality Principle (1911). He also made clear his belief that psychological maturity demands that we dispense with the childish illusion that the universe is the creation of a loving God (Freud 1927). Faced with Clare's longing to return to an Eden-like relationship with God, and his fantasy of sleeping, childlike, in the fused embrace of mother earth and father sky, Freud would have assumed that he was dealing with an infantile regression (Freud 1926, p.127f). The spiritual content of Clare's fantasy would have been of little interest to him beyond the fact that it pointed to a catastrophic failure in some developmental task.

Within the framework of the analytic relationship - which may have provided Clare with less exalted but more stable containment than 'the grass below – above the vaulted sky', Freud would have offered the possibility of a process through which Clare's psychotic regression might sufficiently recover for understanding to take the place of incoherence, and mourning for the lost object to replace the denial of loss (Freud 1917). This would have to take place through the analysis of the transference - the fluctuations in the emotional relationship between patient and analyst as it becomes the theatre in which past emotional entanglements are re-enacted (Racker, 1968).

Jung re-visited

Carl Jung would also have noted the regressive nature of Clare's fantasy but believing as he did that conscious and unconscious processes function in a compensatory relationship, would have seen this fantasy as an attempt by Clare's psyche to engender self-healing (Jung, 1967). Specifically, Clare's ego had taken refuge in an archetype of divine nurture - suggested by the transpersonal imagery of the third stanza of the poem - where it had found an emergency holding ground.

In health, this archetype finds expression in the unfolding infant-mother relationship and in the ever-widening circle of relationships that develop through childhood (Neumann, 1976). In Clare's case, however, there would seem to have been a breakdown in his object relations and the only comfort he can now find is in the fantasy of sleeping in the arms of God.

Clare's ringing words, 'I am and live', could simply be asserting that he is still alive and clinging to his identity. But Jung, familiar with psychotic states of mind, would doubtless have heard an echo with the Hebrew name for God - YHWH, I AM THAT I AM, suggesting that Clare is hovering on the brink of a catastrophic inflation of the ego in which he has identified himself with God (Jung, 1958).

How might Jung have worked with Clare's fragile ego? One possibility would have been to explore whether the fantasy of sleeping sweetly like a child, the grass below and the sky above, could become the beginning of a process of 'active imagination' (Samuels *et al*, 1986) in which the psyche itself might furnish the ingredients needed for Clare's healing. This would be delicate work.

If it turned out that Clare adhered concretely to his fantasy, indicating that symbolic function was lost, this would suggest that a cognitive behavioural rather than an analytical approach should be attempted. If the attempt to engage the fantasy in active imagination led to a marked rise in Clare's anxiety or excitement, increasing the risk of psychotic fragmentation, psychotherapy with medication as an adjunct might be possible. On the other hand, if Clare proved able to engage with his fantasy in such a way that a story began to unfold, this would suggest that a Jungian approach was suitable for him. Crucial, here, would be the psychiatrist's ability to reflect on the accumulating material in a symbolic way, not directly challenging or disputing Clare's more literal spiritual imagery but gently making connections between the emerging myth and the outward circumstances of his life and developmental history, in so far as this was known.

Freud and Jung had many theoretical and technical differences, but each, in his own way, was devoted to his patients, and would have made enormous efforts to create a relationship with Clare, the one thing he so conspicuously lacked. Who can say to what extent such devotion would not have been the most powerful therapeutic factor?

Converging pathways

In describing the Jungian way of working, we have ventured into the transpersonal field, being concerned with experiences in which the psyche expands beyond the confines of the personal self and connects with a larger, more meaningful reality.

Historically, this vision of the greater whole can be traced to one of the great pioneers of psychology, William James (1842-1910). His humane and

pragmatic approach to psychology and, most of all, his lectures on the varieties of religious experience (1960) set the 'gold standard' for the psychological study of religion for the next hundred years. The breadth of his vision is evident from the following passage:

> *'Our normal waking consciousness, rational consciousness as we call it, is but one special type of consciousness, whilst all about it, parted from it by the filmiest of screens, there lie potential forms of consciousness entirely different. We may go through life without suspecting their existence; but apply the requisite stimulus, and at a touch they are there in all their completeness* [James, 1960, p.374].

Such shifts in consciousness, in which the ego is transcended, are often accompanied by profound religious or spiritual awakening. The focus, however, can be secular, as in the expression of a compassionate concern for humankind, all life, nature and the planet.

James maintained a down-to-earth approach to the value of religious beliefs, sympathetically evaluating a wide range of first-hand reports of religious experiences and always ready to subject his own beliefs to scrutiny. He remained agnostic about the ultimate source of spiritual experience, yet he was convinced that our lives are in some way continuous with a higher power which, when experienced as benign, has a demonstrably beneficial effect on our lives. (Thus, he anticipated by some 70 years the research that later would show the positive effects of spirituality on health, both physical and mental.) James concluded that for practical purposes, belief in the chance of salvation was enough, because 'the existence of the chance makes the difference… between a life of which the keynote is resignation and a life of which the keynote is hope' (1960: p.500).

James reminds us that whatever our own personal beliefs may be, we should never underestimate the importance of our patients being allowed to come to their own meaningful experience of subjective reality and of the healing properties of religious experience. In John Clare's words, 'There to abide with my Creator, God, and sleep as I in childhood sweetly slept', the soul that has not been able to withstand life's anguish seeks replenishment and healing. In our further discussion of soul-centred therapy, we shall be suggesting how the patient's spiritual reality can be directly engaged as a powerful therapeutic tool.

We next turn to Viktor Frankl (1905–1997), a Jewish psychiatrist and psychotherapist who survived four Nazi concentration camps in which his mother, father, brother, and wife perished, included here because, although coming from the mainstream of psychiatry, his ideas form a bridge with more specifically transpersonal interventions.

Frankl's experiences formed the basis for an existential psychotherapy he called 'logotherapy', founded on spirituality in the sense of humankind's 'will to find meaning' (1973: p.10). Three major insights inform Frankl's work: first, that we can detach from the oppression in which we may find ourselves;

second, that in doing so, no matter what the outward circumstance, we are free to choose and uphold the values by which we live and die; and third, that living or dying with dignity requires a framework of meaning which can embrace suffering as well as health. Frankl quotes Nietzsche, 'He who knows a "why" for living, will surmount almost every "how"', and goes on to say,

> *'while the concern of most people was summed up by the question, 'Will we survive the [concentration] camp?' – for if not, then this suffering has no sense – the question which in contrast beset me was, 'Has this whole suffering, this dying, a meaning?' – for if not, then ultimately there is no sense to surviving. For a life whose meaning stands or falls upon whether one survives or not, a life, that is, whose meaning depends upon such a happenstance, such a life would not really be worth living at all' [Frankl, 1967: p.102].*

Reading John Clare's poem in the light of Frankl's experience, we would seek to discover what part the loss of meaning played in Clare's illness. Was the loss of meaning consequent upon his breakdown or did he break down because he was no longer able to make sense of his existence? Either way, loss of meaning leads to loss of control, for when we cease to understand our experience we lose the ability to take meaningful action in relation to it.

More recently, Frankl's work has influenced the development of spiritually augmented cognitive behavioural therapy (D'Souza & Rodrigo, 2004). But here we want to highlight Frankl's emphasis on the meaning both of living and dying. A life that only holds meaning in relation to personal survival will always be profoundly threatened by the prospect of loss, whether this is of health, or relationships or ultimately, death.

The larger, transpersonal perspective is one that bestows on each life an enduring value that transcends death. For those who have children, there is the hope that the love shown them will bear fruit in the fullness of their lives, and for generations thereafter. For some, it is the value of service to community and friendships, while for others there is the hope that one's professional work will make a contribution, however small, to the progress of humankind. All these would be expressions of humanistic spirituality.

Frankl tried to help his patients, many of whom were also Holocaust survivors, find value and meaning for continuing to live now. In addition, most religions also hold that this life prepares us for the next one. Regardless of which view psychiatrists and other mental health professionals privately may take, empathically relating to the patient's personal framework of meaning and purpose is crucial when making the diagnosis of a mental disorder.[2]

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[2] This is not easy, for as psychiatrists, we are obliged to make judgements about what is supposed to be normal and abnormal. A delusion is defined as pathological because the fixed idea is held contrary to other people's beliefs; indeed, the diagnosis of illness is sometimes made on these grounds alone. Further, because the suffering that a mentally ill person inflicts may be more evident on the lives of others than on self (attributed to lack of insight), neither is personal suffering required for the diagnosis of mental illness.

Transpersonal Psychology

We will now attempt to demonstrate how a broad understanding of the relationship of spirituality to psychotherapy may be given more specific therapeutic focus by outlining developments within the burgeoning field of transpersonal psychology.

Set against the broad perspectives offered by William James, Carl Jung and Viktor Frankl, transpersonal psychology has evolved as a body of theory and practice along a number of avenues. From within the psychotherapeutic tradition there is the pioneering work of Robert Assagioli (1888–1974), who first formulated psychosynthesis in 1910. Assagioli's metapsychology (Assagioli, 1965) incorporates Jung's collective unconscious but specifically locates a 'central self' positioned midway between the unconscious and what Assagioli calls the 'superconscious'. The central self engages with the attributes of personality listed by Assagioli (thought, intuition, imagination, emotion-feeling, sensation, and impulse-desire), but is not to be confused with these attributes, for it is comprised purely of consciousness and will. (The similarity with Buddhism is evident here - meditation enables the self to dis-identify with desires and attachments, since its essence is not the substance of those emotions).

In psychosynthesis, there are two, sequential therapeutic tasks. First there is the secure integration of personality around the central self, not so different from the aim of much psychotherapy and essential for healthy 'grounding'. The second task is transpersonal, focusing on a point of universal consciousness and will, conceptualised within the superconscious realm and known as the 'transpersonal self'. The therapeutic aim is to find alignment with, and to express, the energies of the transpersonal self. In doing so, we are led to recognise that ultimately we are all one, and with that understanding there arises a global perspective characterised by social cooperation, altruistic love, and a transpersonal vision of spiritual evolution.

Another pathway comes from the religious and mystical tradition. Pierre Teilhard de Chardin (1881–1955) was a visionary French Jesuit, palaeontologist and philosopher who sought to integrate Christian theology with natural science and evolutionary theory. He suggested that the Earth, in its evolutionary unfolding, is growing from the biosphere towards a new organ of consciousness, called the noosphere, analogous on the planetary level with the evolution of the cerebral cortex in the human species. Teilhard saw this emerging global information network as heralding a massive convergence of minds, resulting in what he called the 'Omega Point' (Teilhard de Chardin 1959). Such a global information flow has been compared to the growth of the Internet, but Teilhard's vision is anticipating the spiritual evolution of humankind, characterised by a profound ethic and expressed through universal love.

Teilhard's Western evolutionary spirituality can be compared with that of Sri Aurobindo (1872–1950), a scholar, mystic, yogi and evolutionary philosopher.

Educated in England, Aurobindo later returned to India where he became involved in extreme nationalist politics. He was sent to prison, where he turned to the Bhagavad-Gita. On his release he began a life of intensive meditation, establishing an ashram at Pondicherry and teaching 'integral yoga', which aims to advance global consciousness to the divine level. Sri Aurobindo (1939) linked the ancient tradition of Vedantic thought with spiritual evolution through the generative power of what he called 'supermind'. He envisioned the eventual spiritual destiny of humankind as coming about through the effort of individuals to transform their level of consciousness (cf. the aphorism: 'if you want to change the world, first change yourself'), leading collectively to a divine state of consciousness in which the Absolute is experienced as 'infinite existence, infinite consciousness and infinite delight'.

A further contribution to the transpersonal field comes from the study of entheogens, popularly known as psychedelics. There is a long tradition of the ritual use of entheogens in the shamanic tradition of indigenous cultures worldwide, which has been studied participatively by anthropologists such as Narby (1998).

In the West, there was much interest in Aldous Huxley's book, *The Doors of Perception* (1954), in which he gave a detailed account of his experimentation with mescaline. He suggested that ordinary consciousness was the result of the brain filtering out the awareness of information that would otherwise be overwhelming. Certainly the effect of entheogens like lysergic acid diethylamide (LSD), which first became popular as a recreational drug in the 1960s, is to open the mind to a transcendental reality which can be terrifying or ecstatic, according to the susceptibilities of the individual.

At around the same time, the psychiatrist Stanislav Grof began systematically researching non-ordinary states of consciousness using LSD under laboratory conditions. When the drug was proscribed, even for research purposes, Grof developed a breathing/sensory input programme (Holotropic Breathwork[TM]) to induce a comparable altered state of consciousness (Grof 1993). Grof highlights the role of the birth experience in shaping the emotional disposition of later years and has closely studied the relationship of psychotic breakdown to 'spiritual emergency' (see chapter 11, pp. 227-230, for further details). Grof's clinical findings have been buttressed by the theoretical writings of Ken Wilbur (1996) and linked to the Vedic concept of the chakras by the psychiatrist John Nelson (1994).

Yet another contribution to transpersonal psychology comes from a range of experiences that appear to defy the limits of space-time, according to the conventions of classical physics. They include mediumship (Solomon & Solomon, 2003; Fontana, 2005;), paranormal experiments (Radin, 1997), research on life after death (Schwartz & Simon, 2002), the near-death experience (Bailey & Yates, 1996), re-incarnation studies (Stevenson, 1966; 1997) and, by means of working hypnotherapeutically, past-life regression (Woolger, 1999), life-between-life therapy (Newton, 1998; 2002) and spirit release therapy (Baldwin, 1992; Powell, 2006). There is heated debate about the scientific status of these areas of work, for they profoundly challenge the

world view of material realism. Yet the evidence base for paranormal phenomena is strong and even hardened sceptics need to be aware of the research that is taking place. Simply asserting that such things are 'impossible', which once was a legitimate scientific position to take, now betrays ignorance and prejudice; the case against, if it is to be argued, deserves to be reasoned as carefully as the case for. As for practitioners working with altered states of consciousness, they will generally answer by saying that it is more important for them to be able to help the patient get better than to worry about exactly how it happened.

Soul-centred therapy

How might psychiatrists who find themselves broadly in sympathy with the ideas presented in this chapter offer soul-centred interventions in clinical practice? The Humanistic and Integrative Psychotherapy Section of the United Kingdom Council for Psychotherapy accredits a number of relevant trainings but relatively few psychiatrists will wish to undertake such a specialisation. Yet much can be offered by way of simple, compassionate interventions that can enable the patient to feel deeply supported, acknowledged and encouraged in times of crisis. Therefore, we shall conclude with vignettes that illustrate the kind of situation where an intuitively soul-centred approach can be helpful (case studies 6.1-6.4)

Life and death situations most commonly put us in touch with Soul, yet our intuitive response to loss is not given credence in our society (Powell, 2007). For instance, it is well known that the bereaved may see or hear their loved one in the wake of loss (case study 6.1). However, many psychiatrists dismiss this as an emotionally driven misperception and the patient will probably be simply reassured that to imagine such things is normal.

There is an alternative – to work there and then with a person's intuitive faculties. When we are told, for instance, that the patient saw the deceased standing at the foot of the bed on the night of the funeral, an opportunity arises to treat it not as a statistical happenstance but as communication from Soul and to enquire, 'How did he/she look? Did he/she say anything? How did you feel? What importance has this for you?' Some patients are afraid they may be thought mad; others are apprehensive for religious reasons – for instance, the Bible prohibits contact with 'familiar spirits' (Leviticus 19:31, 20:6, Deuteronomy 18:11). However, when reassured, the patient will frequently report having felt comforted by the visitation. Such experiences are far from rare, if we include sensing as well as seeing; either way, an important connection has been explored.

A problem for secular Western society is that when someone dies, it seems that nothing else remains to be done except helplessly grieving the absence of the loved one. However, where the soul is recognised as continuing on its journey, there is an important role for the bereaved to fulfil in the form of prayers and blessings, specifically to support the departed soul in moving on to its spiritual destination. This is an act of continuing love and concern, the

parting being, so to speak, a comma rather than a full stop. Further, the emotions of loss can be usefully harnessed rather than repressed, as can happen when overwhelming defences against loss are activated.

Another difficulty is that prayers and blessings may be felt to be the province of priest and Church, so that the bereaved feel their own personal contribution is less important. Yet transpersonal research suggests that those bereaved are exactly the ones to be actively involved and that nothing is of greater help to a departed soul in being lovingly supported in 'moving on', rather than be detained by the anguish of the loved ones left behind.

It is therefore always important respectfully to ask about the patient's religious and spiritual beliefs (Culliford, 2007). If no definitive view is given, it can then be helpful to enquire whether a person believes that life exists only from birth to death. The majority of patients confide that they have wondered whether life continues after death but are liable to add, 'you probably think its silly of me' or words to that effect. Again, with further reassurance, it may be possible to enquire, 'If it is so, how do you imagine it might be?' This can open the door to working psychotherapeutically with the patient's intuitive faculty (case studies 6.1 and 6.2) (Powell, 1998).

Case study 6.1

> *Joan presented with depression after the death of her husband Ted, having nursed him through a long and debilitating illness. They had been together some 40 years and her loss had left her stricken with grief. Each new day was a living nightmare. She continually felt Ted's presence around the house but it only brought her pain. Yes, it was possible that life after death continued on in some way, but how could that help her now? So Joan was asked if she would like to try to make contact with Ted in a way that might help bring her peace of mind.*
>
> *At the psychiatrist's suggestion Joan shut her eyes, relaxed, and was encouraged to see if she could 'find' Ted wherever he might be. After a couple of minutes, a faint smile played on her lips. The psychiatrist asked Joan what she saw. She replied that she could see Ted in his cricket whites playing cricket and looking very fit and happy. The psychiatrist remarked that Ted seemed to be enjoying a game of celestial cricket! Joan's smile widened and she added that cricket had been Ted's great passion. Then a look of deep sadness passed across her face. Asked whether she would like to speak with Ted, she nodded. So the psychiatrist suggested she 'walk up to him' and see what might happen. After a moment, Joan said that she was now standing next to him and he had put his arm around her. What was he saying? He was saying 'Don't worry; everything is going to be all right.' Joan was asked to look around her. Was there anyone else present? Then she could see her deceased sister and parents smiling and waving to her.*

Joan's vivid experience can be interpreted at the psychological level of object loss, on the transpersonal level of connecting with Spirit, or both. It is often

best left undefined, simply as an experience that the patient can return to, feel reassured by and as a way of finding healing according to the need.

Case study 6.2

> *Christine attended with a history of chronic depression that had not responded to antidepressants. Her personal background had been a childhood of severe deprivation. She grew up lonely, wanting to make relationships but unable to access her own capacity to love, or to feel worthy of love.*
>
> *Christine was asked if she felt able to 'look' into the black cave, which is how she described her depression, and with the help of the psychiatrist to see if any answers lay within.*
>
> *Christine's first response to going into this dark place was that it was cold and empty. After a few minutes she reported finding a pair of steel handcuffs on the stone floor. Then she found a rope and soon after, an iron chain. It is not hard to imagine what these objects said about her bleak and lonely inner world. Christine was now getting into something of a panic. She was pressed to go on looking. Then, after what seemed an eternity, her expression changed to one of concern. The psychiatrist asked her, 'What now?' She had found a little puppy in a dark corner. He suggested she pick it up and hold it to her. With her eyes still closed, she cradled the puppy. What could she feel? She replied that she could feel the puppy's love for her. She was urged to let her own love flow to the puppy at the same time. She began to cry. After a pause, the psychiatrist asked her to find an image for the emotion that flowed within her and she chose a heart made of gold. Then she was invited to picture a sunbeam falling on this golden heart so she could see it in all its beauty.*

In case study 6.2, at the psychological level, the puppy symbolizes the child Christine. She loves and nurtures this child-self, which she had thought was lost forever and in doing so discovers that she still has the capacity for love. In terms of spiritual object relations, we can see the experience as helping Christine retrieve her soul that had got buried in the wasteland of her childhood.

From the spiritual perspective, deprivation and abuse in childhood is a double blow. The damage sustained on the psychological level to the child's internal object world would be bad enough. However, the child's 'spiritual object relations' have also been denied. From the transpersonal perspective, this is our pre-existing soul connection with the Divine, which inspires our original sense of goodness and which forms the template on which human object relations are laid. Not surprisingly, re-connecting with Soul is an invaluable asset when seeking integration and healing of the traumatised self, as shown in case studies 6.3 and 6.4 (Powell, 2003).

Case study 6.3

> *Carol's story had been one of terrible abuse and hardship and for many years she had taken refuge in alcohol. During the first interview, she was encouraged to look inside herself and describe what she found there. What Carol saw was 'her heart beating so hard it could burst'. What did she want to do with it? She put it to rest in a silk lined coffin, saying 'only death will bring it peace'. But then after a moment the heart transformed into a little whirligig of energy. It would not be trapped but flew about the room. So she released it and watched it fly away.*

Images of the soul are incapable of death, being our personal quotient of eternal and infinite consciousness. But Carol was not ready or able to harness her soul for her own benefit. She did not take up the offer of therapy, which would have meant abstaining from alcohol.

> *Nearly 4 years later Carol came to see the psychiatrist again, in the meantime having faced up to her drinking. This time, she went inside herself, into a dark cave, where she found a treasure chest. The psychiatrist asked if she could pick up the treasure chest and see if there was any way out. She put it under her arm and soon found an archway and went through. Now she found herself in a sandy desert, by a pool of water and some trees. She sat by the water, resting peacefully and said with a sigh, 'This is for me!' (All her life she has rushed around trying to please others). Did she want a drink? She drank deeply of the cool fresh water. Now where did she need to go? She immediately found herself back home, still holding the treasure chest, studded with jewels and very beautiful. She placed it on the floor in the middle of the room. Following this session, therapy was offered and accepted.*

Sometimes when the heart has been sorely wounded, the need is to find healing.

Case study 6.4.

> *A young man, Roger, who had suffered great distress as a teenager, sought help. At the time, he had been encouraged to seek guidance from a priest, with disastrous results. The priest was untrained in psychotherapy but took it on himself to convince Roger that his problems all stemmed from the fact that his parents had never loved him. This wasn't true - the priest was massively projecting his own problem onto Roger - but the young man was vulnerable and started to believe his mentor. Soon he became deeply alienated from his parents, which only worsened his isolation and depression.*

After a period of psychotherapy, the effects of the abuse by this priest had largely been overcome. However, at follow-up a year later, Roger reported that he could still feel something wrong, for there was a persisting sensation

of physical discomfort. He explained, 'it's as if a big splint has entered the right side of my neck and gone down through my chest'.

> *Roger was asked what this splint, if it could speak, would say. The answer came straight back. 'Anger!' The psychiatrist speculated that Roger's anger with the priest may have acted like a splint to keep him functioning, but rather than trying to interpret this, he asked Roger what should be done about it. Roger said despairingly 'I don't know - it's part of me'. The psychiatrist suggested he try closing his eyes and to allow himself to float upwards and away from his body, then simply to observe himself down there sitting in the chair with his problem. The question was repeated and this time without a second's hesitation Roger said emphatically, 'I need to pull it out!' With encouragement, this is what he visualised himself doing, drawing it out inch-by-inch. It left a raw wound in its track. How was he going to dispose of it? Roger answered, 'I want to put it in the garden, and let it weather away naturally, like wood'. The session was concluded by spending time envisaging cleansing and anointing the wound until Roger was satisfied with the result.*

When we are able to dis-identify with the problem, there is the chance for ego to make way for Soul, and the soul in its wisdom guides us to find the right response, in this case for healing of an old wound to take place.

Closing remarks

In this chapter the authors have set out a unitive way of thinking about the relationship between spirituality, psychiatry and psychotherapy. We have expanded on John Clare's poem *I AM* because it powerfully articulates the distress of many mental health patients. After a survey of psychotherapeutic approaches including the transpersonal, we have described how soul-centred interventions can engage with the spiritual reality of the patient.

We acknowledge the value of more traditional and lengthy psychotherapeutic approaches but we are well aware of the constraints on time and opportunity when working in the acute clinical services. This is where the brief soul-centred approach can be particularly helpful. Our patients come to us distressed and frequently staring into the abyss, seeking the warmth of genuine human contact, yet often afraid to ask. We know from discussions within the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists that many mental health professionals have the sincere wish to respond soul-to-soul, a desire echoed by patients' representatives on the National Spirituality and Mental Health Forum; yet, this very human dimension of our work has not received much attention within the profession to date.

We can take heart from our roots. The etymology of psychiatry is *psyche*, soul, and *iatros*, doctor; and for psychotherapy, it is *therapeuein*, to take care of, to heal. Albert Einstein remarked, 'the intuitive mind is a sacred gift and the

rational mind is a faithful servant' (1931). When soul leads and science follows, we can be assured of the best of both worlds.

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