‘Furthering the spiritual dimension of psychiatry in the United Kingdom’

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Introduction

In this paper, I shall be focusing, quite narrowly, on spirituality in psychiatry, as opposed to the wider compass of mental healthcare, and steering well clear of the schisms that arise from religious differences. However, I first want to distinguish between spirituality and religion:

> ***Religion****: an organised system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality).*
>
> ***Spirituality****: the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship with the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community.*
>
> (Koenig, H. K., McCullough, M. E. & Larson, D. B. (2001*) Handbook of Religion and Health.* OUP)

A further definition of spirituality is given on the website of the Royal College of Psychiatrists’ Spirituality and Psychiatry Special Interest Group:

> *‘**Spirituality** can be as broad as 'the essentially human, personal and interpersonal dimension, which integrates and transcends the cultural, religious, psychological, social and emotional aspects of the person' or more specifically concerned with ‘soul’ or ‘spirit’’.*
>
> *www.rcpsych.ac.uk/spirit*

Lastly, in this age of high-technology medicine, a welcome reminder from the World Health Organisation concerning the broader context of healthcare:

> *Health is ‘a state of complete physical, mental and social well-being, not merely the absence of disease’*
>
> and
>
> *… ‘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’.*

Psychiatry and scientific realism

In order to see where psychiatry has been heading, it helps to understand something of its history. Current mental health science is largely dismissive of pre-scientific reality as 'primitive' and 'animistic'. For instance, the shamanic view of 'spirit', which has informed cultures as far apart as Northern Asia, Mongolia, the Inuit, North American Indians, the tribes of the Amazon Basin, the aboriginal culture and in Europe, the Celts, is these days of interest only to medical anthropologists.

Yet contemporary psychiatry shows the same indifference towards the major faith traditions of today. This becomes more intelligible in then light of Gallup surveys which show that while 80 - 90% of the general population believe in God, or a higher presence, only some 30% psychiatrists and psychologists do so.

I shall be looking at some of the consequences of this discrepancy for mental health services.

Metaphysical beliefs of Western Antiquity

Every culture has a tendency to regard itself as pre-eminent. The culture of Western science is no different, regarding its interpretation of the nature of 'reality' as indisputably true, while treating metaphysical reality is nothing more than 'imagination'. Yet this conceptualisation is just a few hundred years old, and entirely derived from instruments which themselves are comprised of that which they measure.

Let me begin, therefore, by situating Western science against the backdrop of earlier civilisations which, though 'pre-scientific', nevertheless advanced their own traditions of scholarship, wisdom and truth. All of these held there to be an animating principle of life - the Egyptians called it ka, the Greeks called it psyche, meaning 'soul', and the Romans spiritus (from 'breath').

In this discussion, I shall be using the word 'soul', (Old English: Sawol) to mean the unique and irreducible essence of each person, and 'spirit' for the more general animating principle behind matter.

The Greeks saw science and soul as going hand in hand. Pythagorus (6^{th} Century BC) remembered an earlier incarnation as Euphorbus, a warrior in the Trojan War. Later, Socrates was to assert the immortality of the soul, and Plato ($4^{th}/3^{rd}$ Century BC) believed that by virtuous living, the soul is purified and regains its original perfection, while moral dereliction leads to Tarturus (Hell). As to the true nature of reality, Plato used his famous allegory of the cave to liken our perception of reality to mistaking the shadow thrown on the wall of the cave for its source.

Jewish mysticism (Kabbalah), too, has a long and ancient history. 'Hidden teachings' were revealed by angels to Adam and handed down to Noah and Moses. According to The Zohar, souls must reincarnate until the germ planted in them grows to perfection, when they return to the Absolute. Islam, too, has its own mystical tradition in Sufism.

Eastern metaphysics

Turning to the East, we find the same intuited truth in Hinduism, rooted in the Vedas that go back 3500 years. The eternal soul (Atman) is caught in the cycle of birth and death until freed of its sanskaras (past impressions) by purification through yoga.

Daoism, which was refined in the 6th Century BC in China, teaches of 'The Way', the path of perfect balance in harmony with cosmic law. The soul is in two parts, kwei (yin), which is terrestrial and impermanent, and shen (yang), which is celestial and immortal.

The third great Eastern tradition is Buddhism, which originated in India in the 5th Century BC India and spread to China two hundred years later. Karma and re-birth are central to the Buddha's teachings on the nature of suffering, its cause, its cessation and how it may be avoided (the noble eightfold path).

The Christian Church – reincarnation denied

The early Gnostics texts - the gospels of Thomas and Philip and the Pistis Sophia - all refer to re-incarnation, while the four synoptic gospels offer no more than hints. In fact, reincarnation was first undermined by the emperor Constantine at the Council of Nicea in 325 AD, when Jesus Christ was declared the *only* son of God (the Nicene Creed). At a stroke, the human race was set apart and made subordinate to the Church, requiring the priest to intercede for the sins of humanity. In 543 AD, at the 5th General Council of Churches convened by the emperor Justinian, the doctrine of reincarnation was anathematised. Gnosis (direct revelation of the Divine) was viewed as potentially subversive and instead, faith, and adherence to the teachings of the Church were given prominence.

Following the fall of the Roman Empire, mediaeval Europe was dominated by Christianity, fuelled by the 11th Century schism between Roman Catholic and Eastern Orthodox Churches. Religious intolerance, as evidenced by the Crusades, and persecution of heretics, was now an established feature of the Christian church.

Despite the power politics of Christianity throughout history, the mystical tradition has nevertheless been upheld by individuals who trusted their personal relationship with God more than obedience to the established order – Hildegard of Bingen, Francis of Assisi, Meister Eckhart, Julian of Norwich, St. John of the Cross, Jakob Boehme, Blaise Pascal, Emanuel Swedenborg, Pierre Teilhard de Chardin and Thomas Merton, to name but a few. It is the mystical tradition about which we psychiatrists particularly need to know, for our patients are liable to bring to the consulting room not the catechism or the liturgy, but direct experience of God and, not infrequently, the Devil too.

The scourge of Evil and the fate of the mentally ill

The prospect was not good for those suffering from serious mental disorder in mediaeval Britain. In 1401, the first Act of Parliament against witchcraft was passed. The water test was usually decisive; the accused was thrown into a pond, bound hand and foot. Those who sank were declared innocent and survived, if they were lucky enough to be pulled out of the water

before drowning, while those who floated were found guilty and burned at the stake.

A further Act of Parliament followed in 1604, which determined 'Death without benefit of clergy to anyone who invoked evil spirits or communed with familiar spirits'. Around 1000 people, mostly women, were put to death in the UK and some 40,000 in Europe prior to the 1735 Witchcraft Act of George III, when hanging was replaced with imprisonment.

Incidentally, the last prosecution took place in 1944 when the Medium, Helen Duncan, was imprisoned for nine months under the Act for 'betraying details of the D-Day preparations via pretended contacts with the spirit world'. The Witchcraft Act of 1735 was finally repealed in 1951.

The Renaissance: a two-edged sword

The hegemony of the Church in Europe was broken by the Renaissance. At the turn of the 15th Century, Copernicus challenged the geocentric worldview of Catholicism and Galileo was sentenced to life imprisonment for subsequently demonstrating that the solar system to be heliocentric. The force for change, however, was inexorable.

Renee Descartes (1596 - 1650) claimed that 'nothing is held to be true until one is absolutely certain of it'. 'Cogito, ergo sum'. Yet since the one thing Descartes could not doubt was his own existence, in doing so he gave primacy of mind over matter. Descartes also said: *'To be capable of so perfect an idea as God means that such an idea could not have been caused by anything less perfect than God. Therefore both classes of substance, body (res extensa) and mind (res cogitans), are created by God'*

Isaac Newton (1642 -1727), who published the laws of gravitation and motion in his historic work Principia Mathematica, was also a deeply religious man. Newton held the universe to have been created by God, stating that *'Truth is the offspring of silent, unbroken meditation'*.

The profound discoveries of Descartes and Newton set in motion a revolution that by the 18th Century had led to the 'Age of Enlightenment', with the flowering of individualism in the arts, in political and social reform, and with extraordinary progress in science, medicine and technology.

At the same time fateful seeds were sown, for Descartes' dictum, ill-used, served to put Man in the place of God and Newton's physics were misused to relegate God to a Heaven that had no substance except in faith. The result was the birth of material realism, which has taken humankind down a path of alienation from both the spiritual universe and from the wisdom of Nature, leaving us, three hundred years on, facing a planetary crisis of survival.

Pioneering the humanitarian care of the mentally ill

Until the 18th century, those mentally ill but *not* deemed to be witches or possessed by the devil were incarcerated. The Bethlem Royal Hospital, where inmates were put in chains and publicly ridiculed, had been founded as early as 1247 and was popularly known as Bedlam.

A small number of influential reformers finally broke this mould. In Paris, Phillipe Pinell (1745 -1826) instigated 'moral treatment', first at Bicetre Hospital

and then at the Hospice de la Salpetriere. Pinell stopped purging, blistering and bleeding, preferring to talk with his patients. Independently, in this country, William Tuke (1732 -1822), a Quaker, founded The Retreat in York, caring for the afflicted with humanity and concern. John Conolly (1746 - 1866), who became the superintendent of Hanwell Asylum, published a ground-breaking book in 1856 entitled 'Treatment of the Insane without Mechanical Restraints. Conolly advocated providing patients with both occupational and recreational activities, and that they should be treated with kindness.

Care of the mentally ill in the 19th Century

Mental illness was now seen as a medical problem and the treatment given was, for the most part, humane. However, an experiment in social engineering had been taking place through the large scale building of mental asylums that segregated and isolated the patient population. By 1930, over 140,000 patients were residing in such institutions

Some patients benefited; those too disturbed to care for themselves could become part of a community, working on the estate, and taking part in the asylum's organised recreational life.

Many others suffered greatly, having been inappropriately diagnosed in the first place, or sent there for spurious social reasons, sometimes with the diagnosis of 'moral degeneracy' and large numbers of patients were effectively subjected to life imprisonment without trial or appeal.

The establishment of psychiatry: theories of biological causation

By the end of the 19th century, the medicalisation of mental disorder had been firmly established. This was based on the identification of a range of pathologies, including infections (neurosyphilis), physical lesions (tumours and head injuries), biochemical disorders (porphyria), vitamin deficiency (thiamine and B 12) and many others being shown to cause damage to the brain resulting in mental changes. Emil Kraepelin, the 'father of psychiatry', classified severe mental illness into two main categories, schizophrenia and manic-depressive disorder, and psychiatrists optimistically looked forward to discovering the underlying physical causes. Over a hundred years later, in most cases no physical cause has yet been identified.

The development of mainstream psychiatric treatments in the 20th Century

Early 20th Century treatments were limited to medication with opiates, bromides and barbiturates. However, from the '30s onwards, lobotomy was widely performed (40,000 in the USA, 17,000 in the UK). The procedure could be carried out in 10 minutes in a doctor's consulting room, with a probe inserted over the eyeball and shoved into the frontal lobes of the brain. Insulin Coma Therapy was also popular, another intervention that destroyed brain tissue, this time from oxygen starvation. Both treatments wrecked countless lives.

Electroconvulsive therapy (ECT) turned out to be the other mainstay of treatment, and this continues to be used, 12,000 treatments per year currently being carried out in the UK. This is because ECT can relieve intractable depression and is, on occasions, life-saving.

During the ‘50s, antipsychotic drugs became available (for instance, Largactil), tricyclic antidepressants came on the market (Tryptizol), the benzodiazepines (Valium), and the first mood stabiliser (Lithium). In the ‘60s, a new class of antidepressants was discovered, known as MAOIs (Nardil) and since then, two further classes of antidepressants, the SSRIs (Prozac) and the SNRIs (Effexor), as well as a range of other medications.

In parallel with early physical methods of treatment, psychoanalysis had been the psychological therapy of the first half of the century. However, by the 60’s, psychoanalysis was fighting a losing battle, on the one hand with biological psychiatry (since physical treatments were much more useful in treating major mental disorder) and, on the other hand, with behavioural psychology, which was now proving effective in a wide range of conditions.

Nevertheless, biological psychiatry, psychoanalysis and behavioural psychology were all united in one thing: none of them had any time for religion. A leading textbook of the ‘60s by Mayer-Gross, Slater and Roth contains just two references to religion, ‘Religiosity in deteriorated epileptic’ and ‘religious belief, neurotic search for’. This aversion to the spiritual can be better understood when some of the implicit assumptions of 20th Century science are listed.

- Subjective experience does not count. Reality is seen to be something ‘out there’.
- Events take place by chance and become only meaningful statistically when they can be shown to have significantly deviated from occurring by chance.
- Science is reductive/analytic so that a concept like wholeness has no heuristic status.
- Causation is ‘bottom up’ rather than ‘top down’; e.g. the 20th Century scientific view that consciousness must somehow be generated by the activity of brain cells.
- The value of altered states of consciousness, which require a different methodology, are discounted in favour of ‘consensus reality’.
- Despite advances in quantum physics, which show all ‘reality’ to be highly subjective, ‘objectivity’ remains the gold standard (the ‘Newtonian’ worldview).

Besides biological psychiatry and secular psychotherapy, a third strand to contemporary mental healthcare is beginning to make its mark. Although the impact on mainstream psychiatry has, to date, been small, I believe this third strand holds the key to crucial future developments.

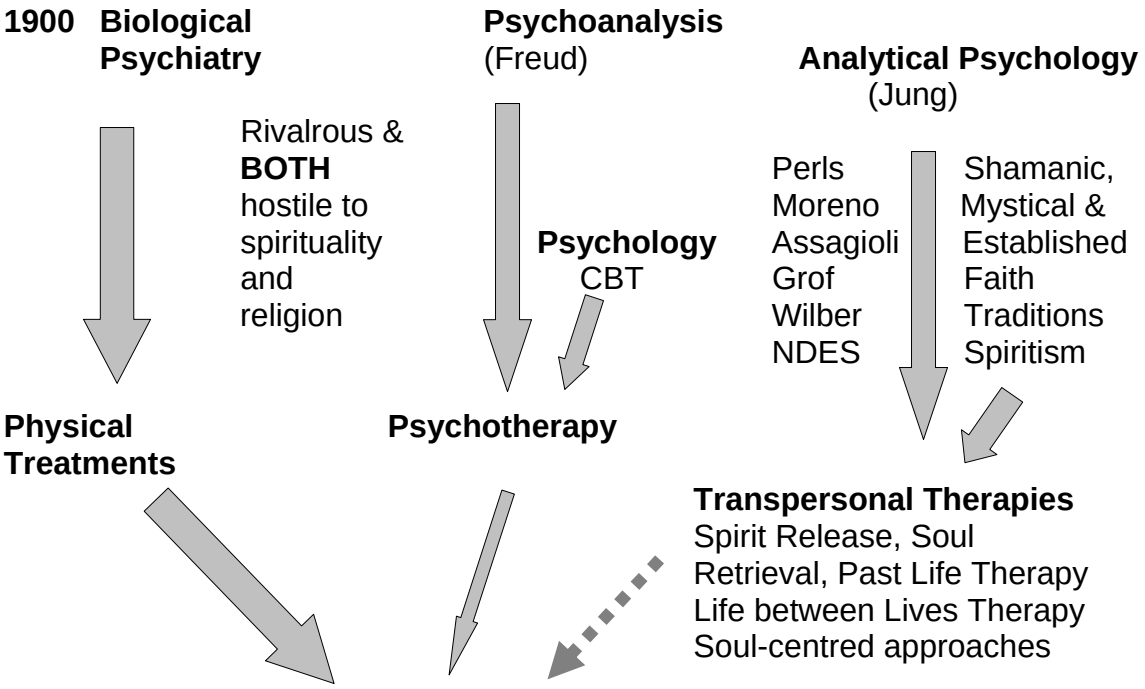
This is transpersonal or soul-centred healthcare. Its origins as a psychological theory lie in the analytical psychology of Carl Jung, while no less drawing on the great religious and mystical traditions for spiritual illumination.

In the United Kingdom, analytical psychology has influenced mainstream healthcare to a certain extent, for there are a small number of consultant psychotherapists in the Health Service with a Jungian background. But the Jungian approach is less concerned with symptom resolution than with ‘individuation’, the development of the ‘whole person’ during the second half of

life. It is therefore out of step with the focussed short-term treatments that are funded and available in the Health Service.

Soul-centred approaches, however, can be highly focussed. The willingness of the patient to work with 'soul' can be elicited when taking a spiritual history - to which I shall be referring later - and then the appropriate intervention made.

The main influences on psychiatry today can be summarised on the flowchart shown below, with relative influence depicted by the arrow size.



The increasing burden of mental illness

Mental disorder has now assumed epidemic proportions. One in ten adults (450 million worldwide) is affected by mental illness, accounting for over 12% of the global burden of disease and rising, according to WHO. In Europe and the Americas, the burden of mental illness is over 40% of the total burden of disability. 25% women and 12% men will suffer a major depressive disorder during their lifetime and 35% of people seriously medically ill are clinically depressed.

In just the first 5 years of Prozac coming on the market, over 10 million prescriptions were issued.

We need to ask ourselves what is going wrong. Is the human race suffering from some kind of biological melt-down? This seems unlikely. More probable, in my view, is that too many of us are living lives estranged from our

spiritual birthright, with its innate values of goodness, beauty and truth. The consequent lack of meaning and purpose is inflicting a terrible price on our health. Let us look at a few of the modern myths which surround the privileged 'First World' in which we live. They are mainly characterised a substitutive addiction to excitement, power and fear.

- Birth is down to chance - a random event
- The way life goes is also largely a matter of luck
- Death is final
- There is no ultimate purpose in life
- Love is selfish – based merely on self-survival
- Get to the top of the heap, make a lot of money and buy pleasure
- Blur the emptiness of life with drugs / alcohol
- Aggression, fear, risk-taking, gambling, make you feel alive
- Sex is a great antidepressant. Have more – thanks to Viagra

Small wonder that the stage is set for breakdown, driven by an underlying spiritual crisis which may not be evident at first sight.

The 'spiritual emergency' in psychiatry

Those easiest to help are patients who can recognise how their symptoms relate to the loss of meaning and purpose in life and who welcome a spiritually-informed therapeutic approach.

A second group will come with a range of emotional or somatic symptoms, which on exploration have their roots in the spiritual arena. Here, it is important that the psychiatrist does not misdiagnose depression, for instance, and treat as such. This can happen if the patient is not encouraged to express his/her spiritual concerns.

The most difficult situation to evaluate is when a patient presents with 'psychotic' symptoms that have a strong religious or spiritual significance, or with Kundalini phenomena. There is no diagnostic entry in ICD-10 (World Health Organisation International Classification of Diseases) for 'spiritual emergency'. There is, however, an entry for 'acute and transient psychotic disorders' (ATPDs) in ICD-10 (F23) including 'acute polymorphic psychotic disorder without symptoms of schizophrenia' (F23.0)

> *'Hallucinations, delusions and perceptual disturbances are obvious but markedly variable, changing form day to day or even from hour to hour. Emotional turmoil, with intense transient feelings of happiness and ecstasy or anxieties and irritability is also frequently present. This disorder is likely to have an abrupt onset and rapid resolution of symptoms; in a large proportion of cases there is no obvious precipitation cause'.*

People suffering from ATPDs recover, by definition, from the episode of illness. However, they do show a relapse rate of up to two thirds and around 40% will eventually be diagnosed as having schizophrenia.

Because most psychiatrists are not attuned to the spiritual dimension, we simply do not know how many of these patients are breaking down because of a spiritual crisis, and neither do we know how a psychospiritual intervention might influence the outcome. One problem is that intense spiritual preoccupations are often regarded by the psychiatrist as a feature of illness, to be minimised when the acute phase passes. Yet sooner or later, the embattled archetypes of good and evil will need addressing, for when the inner struggle is left to continue unaided, it is sure to erupt again. The skill lies in finding a creative way to help the patient work with his/her spiritual concerns that may protect against further breakdown.

Mediumistic phenomena

Another issue at the interface of spirituality and psychiatry concerns trance and spirit communications. Here, ICD 10 acknowledges a problem, not least because of the need to recognise widely varying cultural traditions.

Under F44.3, 'Trance and Possession Disorders', we find:

> *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'. Attention and awareness may be limited to, or concentrated upon only one or two aspects of the immediate environment, and there is often a limited but repeated set of movements, postures and utterances'.*

and

> *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.*

The bad news for all those who believe in the actuality of 'spirit' lies in the 'as if', for Western science does not countenance the possibility of the survival of human consciousness that can communicate across the bounds of space-time. The good news is that Mediums can be reassured that they will not be diagnosed with a mental disorder unless, of course, they happen also to have fallen ill.

The need for a Spirituality and Psychiatry Special Interest Group (SIG)

During the latter years of my consultant work in the Health Service, when my interest in soul-centred psychotherapy was deepening, I became increasingly aware of a number of issues that could usefully be addressed:

- Many psychiatrists unhappy with 'scientific realism' but no forum for debate without risking censure
- Spirituality largely ignored by mainstream psychotherapy
- Psychiatrists not encouraged or trained to explore religious/spiritual concerns and consequently reluctant to engage with topic in clinical practice

- Research by Mental Health Foundation showing over half of patients turn to their spirituality/religion when in crisis but cannot discuss with the psychiatrist
- Need for accurate diagnosis when distinguishing mental illness from spiritual crisis, especially when archetypal spiritual/religious themes are central
- Unsure as to what status/credibility to give to 'paranormal' phenomena
- Soul-centred therapies largely unavailable within NHS
- Ignorance of research correlating spirituality and positive mental health

It seemed, therefore, a propitious time to form a Special Interest Group, one which would align psychiatry with its intended meaning of 'psyche' soul, and 'iatros', doctor. Colleagues were canvassed, a proposal was put forward to the Royal College of Psychiatrists and a working group was established. Our inaugural meeting was held in September 1999 and the first programme of the SIG took place in January 2000. Since then, the membership of the group has grown to more than 1,500 psychiatrists.

The role of the Spirituality and Psychiatry Special Interest Group, Royal College of Psychiatrists

The proposal put forward to the College stated that the SIG would be a discussion forum for psychiatrists (having no religious bias and respectful of differences) in order to explore:

- Fundamental concerns intrinsic to good mental healthcare such as the purpose and meaning of life, and the problem of good and evil
- The need for an integrative approach (mind/body/spirit)
- Specific experiences invested with spiritual meaning, including birth, death and near-death, mystical and trance states, 'paranormal' phenomena, the 'spiritual emergency', and to distinguish between normal and pathological human experience in the field of mental health
- How best to develop and provide educational input to the Royal College for the training of psychiatrists (professional competencies curriculum, with explicit knowledge, attitude and skills)
- The relationship between illness, health and spirituality, and the growing evidence base associating spirituality with positive mental health (the protective effect against depression and outcome research in the treatment of alcohol and substance abuse, to name just two).

The work of the Spirituality and Psychiatry Special Interest Group

The SIG has been concerned to influence the training that is provided for psychiatrists. We have submitted extensive proposals for the introduction of spirituality into the curriculum for trainees and are awaiting the response of the College. The aims and objectives of what we believe spiritually informed psychiatry should be able to offer are summarised below:

The psychiatrist should be aware of, and responsive to, 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

The psychiatrist should have knowledge of:

- Spiritual crises, meditation, prayer and altered states of consciousness, including the Near Death Experience
- 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 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

The psychiatrist should be familiar with research on:

- 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 neurophysiology and efficacy of prayer, meditation, forgiveness and love

Good psychiatric practice should be informed by:

- Awareness that 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

The psychiatrist should be skilled in:

- Taking a spiritual history
- 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 emotional responses to spiritual disclosures
- Honest self-appraisal, in the interests of continuing personal development
- Maintaining personal well-being in the interests of patient care

Taking a spiritual history should include enquiring:

- What is the patient's spiritual / religious background?
- What role did spirituality / religion play in childhood, and how does the patient feel about that?
- Is spirituality / religion important now in the patient's life?
- If so, are such beliefs supportive, or anxiety provoking and punitive?
- Is spirituality / religion drawn upon to cope with stress? In what ways?
- Is the patient a member of any spiritual / 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 at ease with?
- Do those beliefs influence how the person feels about taking medication?

Further activities of the Group

The Website www.rcpsych.ac.uk/spirit is in the public domain. The SIG Newsletter is published regularly, with notice of meetings held and details of programmes, which have included:

What do we mean by spirituality and its relation to psychiatry?
Fear and faith - the quandary of the psyche under threat
Avenues to peace of mind
Forgiveness and reconciliation
Engaging the spiritual mind; the healing power of love
Good and Evil - the challenge for psychiatry
Integrating mind and body: psycho-spiritual therapeutics.
Pathways to peace - East meets West
Invited or not, God is here: spiritual aspects of the therapeutic encounter
Minds within minds: the case for spirit release therapy

Spiritual issues in child psychiatry
Prayer in the service of mental health
A fatal wound. Who and what does suicide destroy?
What inspires the psychiatrist? Personal beliefs, attitudes and values
Special needs, special gifts - learning disability and spirituality
Spirituality and religion in later life
Psychosis, psychedelics and the transpersonal Journey
Sanity, sex and the sacred: exploring intersecting realms
Suffering - what is the point of it all?

Public conferences include:

The place of spirituality in psychiatry
Beyond death – does consciousness survive?
Healing from within: the therapeutic power of altered states
Psychotic episode or spiritual emergency? The transformative potential of psychosis in recovery

The wide range of papers presented at meetings given can be downloaded from the SIG website publications archive.

The SIG promotes links with other bodies, such as The Janki Foundation 'Values in Healthcare Programme', The Scientific and Medical Network and The National Institute for Mental Health in England.

An important publication has been the leaflet 'Spirituality and Mental Health', formally approved by The Royal College and available for download from the College website homepage 'topics' menu (www.rcpsych.ac.uk)

A textbook 'Spirituality and Psychiatry' has also been commissioned by the Royal College from the SIG, for publication in 2008.

Where do we go from here?

My belief is that if we are significantly to influence the development of psychiatry in the United Kingdom, our work needs to develop in a number of areas.

We must raise awareness in the profession to paradigm change within science (quantum physics, advances in cosmology, the non-local nature of consciousness, the significance of the near death experience etc.).

More research is needed into the effectiveness of the psycho-spiritual therapies.

Training in psychospiritual therapy should be more widely available. (Provided these therapies can be shown to work, they will find acceptance, even if the mechanism of change is regarded as entirely psychological).

We will continue to advocate a holistic approach - not 'either/or' but 'both/and'. Physical treatments, appropriately and thoughtfully given, especially for severe mental illness can be life-saving; but for healing to take place, it helps to enlist the soul.

In our clinical work, we need to engage with the spiritual reality of the patient and seek to elicit the wisdom he/she already holds. The solution always

lies in the problem, which invariably has been perfectly ‘arranged’ to provide the spur to change and growth.

Science need not stand in the way of the Golden Rule: ‘do unto others as you would have them do unto you’. Doctor and patient are merely roles – each needs the other! We are all travelling along the path of learning, one which ultimately takes us to the same destination.

We can remain optimistic in the most apparently hopeless cases since, from the point of view of soul, there is no such thing as a bad experience.

Last but not least, we should never forget that the healing power of love remains the best medicine known to humankind.

Talk given at the 1st British Congress on Medicine and Spirituality
London 30th June/1st July 2007

For further reading, see the author’s publications on Spirituality and Psychiatry at:
www.rcpsych.ac.uk/college/specialinterestgroups/spirituality/publications.aspx