Integrating Spiritual And Religious Themes In Psychiatric Management
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Citation

Abstract
Psychiatric treatment still remains a challenge. The hurdles in its treatment not only lie on pharmacological shortfalls (selection of appropriate drugs, their dosing and combating the adverse effects), but also the deep-rooted social ‘taboo’ related to it. The present article is an effort to search how spiritualism and religious themes could be adopted as an adjuvant to today’s psychiatric management. The reason for such integration is that spiritualism and religious feelings are intimately linked with one’s mind. The article tries to extract the influence of ‘religion’ and ‘spiritual’ practices in mental health through a review of the relevant studies available in electronic journal databases. Finally, the article proposes a ‘biopsychosocial model’ that can be implemented as a supportive measure with the present state of psychiatric practice. The article also directs future research related to the neurobiological basis of spirituality.

INTRODUCTION
A tendency for anchoring ‘spiritualism’ and ‘religious paths’ to treat various diseases is an age-old practice in third world countries. Encouragement and acceptance of such indigenous practices are thought to be due to sub-optimal medical facilities, a high degree of illiteracy, and some deep-rooted common beliefs related to the origin and remedy of diseases. Also, those in developed countries show a tendency to adopt religious and spiritual practice for treatment of disease. The boom of science, high quality formal education, sophistication of medical treatment and technology-based acculturations do not necessarily diminish the use of spiritual and religious modes of therapies in the modernized West. This could be because ‘spiritual’ and religious ‘beliefs’ are tightly entwined with one’s mind and therefore have a certain level of acceptability in addition to the more traditional medical approaches for treatment of disease.

The present article is a review of the relevant literature, available in PubMed and PsycINFO. The article describes briefly the background of spiritual and religious practice, several spiritual and religious practices linked with psychiatry, spiritual and religious beliefs commonly practiced by mentally ill patients, and the methods of worshiping and their roles toward mental health. Also, the article studies the emerging concepts for utilizing spiritual and religious practice in psychiatry management and shows a biopsychosocial model, which can be intermingled with modern day psychiatry practice. Finally future directions are suggested for understanding the neurophysiological basis of spiritual and religious healing in mental health.

BACKGROUND
Retrospective studies of the ‘spiritual autobiography’ of the holy saints of the seventeenth century review a lot of conceptual changes in spiritual themes translated into psychiatric idioms of nineteenth century (1). Ancient themes related to spiritualism and religious bias changed in shape and texture leading to a new concept of spiritualism. These are mostly in acceptable terms to the ‘modern’ worshipers.

To find the possible etiological link between spiritual and religious beliefs with mental health, Bathgate (2) studied the conceptual-bridge between psychiatry (especially the psychotherapeutic approach) and religion plus spiritual roles in one’s life by virtue of cognitive science. Individual importance through the ‘psychobiological aspects’ under the reference of the Western religious and spiritual concepts was the theme of the study. The author also found that psychobiology and religious and spiritual concepts related to mental health ‘share a belief in the existence of a transcendent mind’. Hinterheuber (3) also tried to bridge body, soul, and mind or ‘psyche’ (coined by Freud). The author finally concluded that study of psychiatry could be the only way of connections of many of the eternal queries,
like, the origin of soul, its transition and its end (emancipation). Therefore, understanding psychiatry can lead to the understanding of one's soul.

**CURRENT STATE OF KNOWLEDGE ABOUT SPIRITUAL PRACTICES**

This section describes different kinds of spiritual and religious practices related to mental health.

**SHAMANIC PRACTICE**

In traditional shamanic practice, the shamans travel to the state of ‘ecstasy’ by virtue of hallucinogen-intake or by experiencing extreme stress and pain to the body and mind to achieve ecstasy. In today's culture, traditional shamanic practitioners prefer rhythmic noise of 'biting drum' instead of hallucinogens or extreme physical stress. Such recent trends are popularly known as neo-shamanism. The possible reasons for such transition could be the legal obstruction for procuring and using hallucinogens, the adverse affects of using hallucinogens, and the relative ease for practicing neo-shamanism. Some claim that neo-shamanism has a beneficiary role in modern psychiatric practice with regard to psychological and emotional healing. For example, 'Psychopomp' ("guiding the spirits of the dead to their resting places in the other worlds") is a way for psychological healing.

**ZEN BUDDHISM**

Cooper discusses an interactive dynamic of ‘Zen' Buddhist teachings of Hui-neng and the 'psychoanalytic writing' of Wilfred Bion. Cooper explains 'the human tendency to concretize experiential states engendered through meditation and the psychoanalytic encounter'. Cooper also uses the 'symmetrical' and 'asymmetrical' perceptual modalities from Matte-Blanco's explanation to understand the 'fluid state' of the soul. Finally, Cooper proposes that both disciplines, especially with regard to 'the experiencing subject's momentary state of consciousness' could be applied in psychiatry to create core themes using principles from both Zen and psychoanalysis.

**ASCLEPIAN VIEW**

Whitehead analyzed the Asclepian myth for use in psychoanalysis. The Asclepian model incorporates a multi-modal approach linked to today's 'psychosomatic model'. The indigenousness concepts of the Asclepian view could be included with the treatment approaches now very common in modern psychodynamic psychotherapy. Whitehead emphasizes the increasing acceptance of the Asclepian view among modern psychoanalysts.

**HINDUISM AND MEDITATION**

Hinduism is largely practiced in the Eastern World. Hindu philosophy and practices can significantly change human personality. Hindu festivals are not only made for enjoyment and prayer for 'the good' through worshiping the images of Gods or Goddesses but also for releasing individual and social stress. Hindu philosophy includes complete submission of one's soul onto the feet of the Gods and such submissiveness could be essential to prevent anxiety, depression and personality disorders.

Hindu philosophy has highlighted the ways of praying to the Gods and that meditation (e.g., yoga) is a way of prayer. Today, themes of meditation have been modified from mere prayer to also increasing the power of concentration and achieving mental tranquility. Today's increasing demands of life, ability-aspiration mismatch and a craze for earning physical comfort are constantly stirring our mind. Meditation is especially useful and practiced throughout the world to stop or prevent such stirring and possible resulting mental agonies. This can possibly help to prevent the emergence of psychiatric illness in the hypersensitive individuals.

In the present section different kinds of spiritual practices and religious feelings were shown to influence mental health. The following section discusses the religious and spiritual beliefs among psychiatric patients.

**IMPACT OF SPIRITUAL AND RELIGIOUS ‘BELIEFS’ AND THEIR ‘METHODS’ OF PRACTICE IN PSYCHIATRIC PATIENTS**

Psychiatric patients often reflect upon religious feelings. This is most likely done to help them cope with their morbidity. Studies have shown that PTSD (Post Traumatic Stress Disorder) patients often rely on religious symbols and practice for buffering the intensity of emotional stress. One study found that religious-minded OCD (Obsessive Compulsive Disorder) patients show religious-oriented obsessions more than non-religious obsessions. Davies et al observed that religious-based delusional ideations and
auditory hallucinations are extremely common in first-
episode religious psychotic groups. This occurs because
religious beliefs are predominant in this particular group of
psychiatric patients. Interestingly, studies have also shown
that religious therapies could help patients suffering from
affective disorder, anxiety disorder, and even schizophrenia.
Moreover, those with schizophrenia show better response to
religious-oriented psychotherapy than those patients
suffering from affective and anxiety disorders (13). Nelson et
al. (14) observed that religious practice could also alleviate
the spiritual well-being in terminally sick depressive
patients.

Different methods of spiritual practice are beneficial in the
course of mental illness. Baetz et al. (15), in a population
study in a Canadian tertiary care psychiatric setting,
observed that ‘worship attenders’ had less severe depressive
episodes, shorter hospital stays, higher satisfaction related to
their lives, and much lower rates of alcohol abuse as
compared to ‘no or less worship attenders’. They also
observed that the development and disease course were not
related to the frequency of prayer. They thus postulated that
‘religious commitments’ and not mere number of prayers
have a significant role in coping with mental illness.
Garroouet et al. (16) noted that spirituality could be a shock
absorber for human-suffering. They found that ‘cultural
spirituality’ decreased suicidal attempts among American
Indians. However, they observed that commitment to
Christianity had no role at all in reducing the rate of suicide.
In another population-study, Kendler et al. (17) analyzed the
role of religiosity on the lifetime psychiatric prevalence
(‘Internalizing factors’) and substance abuse (‘Externalizing
factors’). They interviewed a group of patients suffering
from nine disorders including phobias, major depression,
generalized anxiety disorder, panic disorder, and bulimia
(defined as ‘internalizing’ factors) and the remaining patients
had nicotine, alcohol or other drug dependence and adult
antisocial behavior (defined as ‘externalizing’ factors). The
authors studied whether thankfulness to God, general
religiosity, forgiveness, God as the judge, unvengefulness,
social religiosity, and involvement of God were significantly
associated with psychiatric outcomes. They found that
unvengefulness was associated with the reduced outcome of
‘internalized factors.’ General religiosity, involvement of
God, forgiveness, and God as the judge decreased the load of
‘externalized factors.’ Thankfulness and social religiosity
relieved both the ‘internalized’ and ‘externalized’ factors.

EMERGING CONCEPTS
Grabovac and Ganesan (18) found evidence regarding the
usefulness of religion and spirituality in day-to-day
psychiatric practice. In an interview-based empirical study of
psychiatric residents, they concluded that psychiatric
residents should be trained with religious and spiritual issues
for better treating psychiatric patients.

From the above studies one sees that religion or spiritual
modalities of therapies could be acceptable to psychiatric
patients, provided that it follows the necessary ethical
commitments. It is important to consider that the theme of
one religion may not be acceptable to the other and in that
case, complications related to one’s ‘religious right’ may
arise. To minimize such issues, Lomax et al. (19) proposed
‘ethical considerations’ in the use of psychotherapy
integrated with religion. They observed that the burden of
ethical issues are far less in spiritual psychotherapy as
compared to religious psychotherapy. Spiritual
psychotherapy consists of personal attention, the nature of
work he or she does, and ‘the pursuit of empathic
understanding’. They conclude with suggestions that
systematic spiritual assessment without violating one’s
religious right and also integrating the spiritual and religious
dimensions in a secular way could be one of the mainstay of
the future psychiatric practice.

CONCLUSION
THERAPEUTIC STRATEGIES
- Training priests, pastors, and local spiritual leaders
  how to explore, counsel and practice psychotherapy in the community by including
  scientific approaches
- Training of parents and caregivers of mentally ill patients how to use spiritual support at home
- Training primary health care staff how to adopt and practice spiritual therapy to those psychiatric
  patients with a religious background
- Considering therapeutic counseling programs in temples, mosque, monasteries, synagogues or
  churches in collaboration with mental health hospitals or organizations
- Considering the religious view as a more comprehensive model of illness and coping,
- Psychological education in the community through
Integrating Spiritual And Religious Themes In Psychiatric Management

group discussion or panel discussion ascertaining functional and dysfunctional aspects of religious interpretation

- Value-related therapy: using references from holy books without losing insight of the psychopathology of the disease and modern pharmacological support/treatment

POSSIBLE METHODS

1. Traditional: Confession, prayer, communion, blessings through ‘laying of hands’, showering holy water etc.

2. Encouragement of religious activities: Arranging and participating in religious festivals, pilgrimage, religious exercises, visiting saints as special healers

3. Counseling: religious counseling for the management of psychiatric illnesses.

4. Yoga (Meditation) to pacify the mental agonies and increase self-confidence

5. Medical Attention: Instituting pharmacological agents in the name of God’s ‘prescription’ or advice to prevent treatment dropout.

EXPECTED OUTCOME

Birth of a ‘biopsychosocial model’ (see model 1) of psychiatric management that will lead to:

1. Improvement of self-confidence (based on confidence in God)

2. Enabling people to develop matured patterns of relating to the environment

3. Enhancement of coping with life's increasing demands

4. Preservation of the awareness and the awe of the ultimate spiritual reality, (i.e., God).

FUTURE RESEARCH

A. The acclaimed benefits of neo-shamanism, various ways of worshipping God in different religions, spiritual psychotherapy, meditation are still hypotheses. The studies reviewed are principally based non-biologically-based evidence. Therefore, future research incorporating could be helpful to determine a biological basis. Specifically, nuclear magnetic imaging techniques (especially SPECT and fMRI) could be helpful for determining the areas of brain which are active during different spiritual or religious practices. Moreover, by BOLD (Blood Oxygen Level Dissociation) technology, we can also map the rate of cerebral blood flow and metabolism in the areas stimulated during such activities. The importance of such studies could be as follows:

1. To find whether areas of the brain affected in a particular psychiatric illness are linked with the areas involved during the spiritual practices

2. To find whether spiritual practices affect the pathophysiology of the particular psychiatric illness by altering metabolism in the concerned areas

3. To find whether such metabolic alterations pacify the target symptoms of mental illness.
Results from this approach would further advance the role of spiritual and religious practices using a biological-based approach.

NOTE
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References

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