Integrating Spiritual And Religious Themes In Psychiatric Management

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Citation

S Chattopadhyay. *Integrating Spiritual And Religious Themes In Psychiatric Management*. The Internet Journal of Mental Health. 2004 Volume 2 Number 2.

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 ([4]). 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 ([4]). 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 ([4]). For example, ‘Psychopomp' (“guiding the spirits of the dead to their resting places in the other worlds”) is a way for psychological healing ([4]).

ZEN BUDDHISM

Cooper ([5]) 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 ([6]) 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 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. Subramanium et al ([7]) and Raina et al ([8]) in their well-documented studies show that meditation is a potent healer, especially in chronic alcoholics. Nespor ([9]) also found the usefulness of yoga in the prevention and treatment of complications related to alcohol and drug dependence, psychosomatic disorders, various neuroses, problems related to geriatric psychiatry, anxiety disorders and other related areas.

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 ([10]). One study ([11]) found that religious-minded OCD (Obsessive Compulsive Disorder) patients show religious-oriented obsessions more than non-religious obsessions. Davies et al ([12]) 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. Garroutte 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

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.

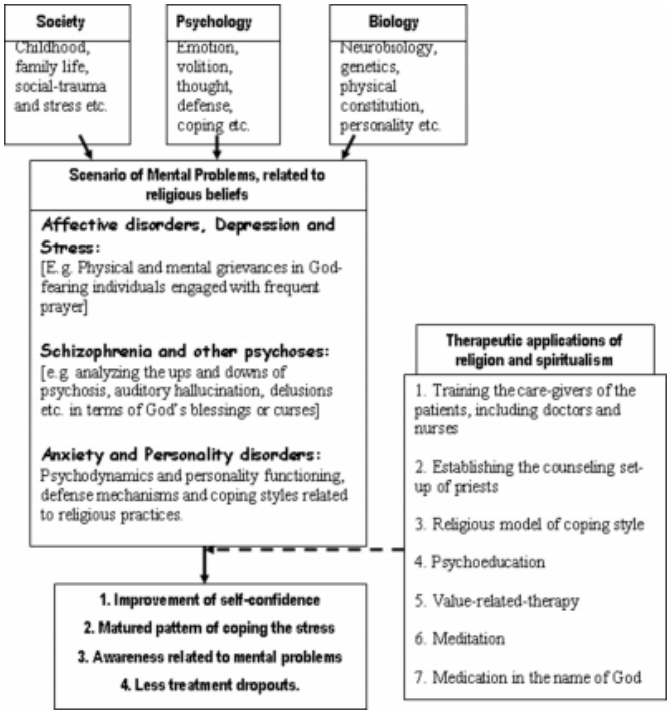
EXPECTED OUTCOME

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).

Figure 1

Model 1: Biopsychosocial model in religious and spiritual practice in psychiatry



FUTURE RESEARCH

A. The acclaimed benefits of neo-shamanism, various ways of worshiping 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

The paper has been presented on 23rd August'03 in the Annual Conference of Psychiatry (Theme: Indian Concepts of Mental Health), held at JSS Medical College and Hospital, Mysore, India (22nd and 23rd August 2003).

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References

1. Leudear I, Sharrock W (2002)- The cases of John Bunyan, part 1.: Taine and Royce. Hist Psychiatry, 13 (51 pt 3): 247-65.
2. Bathgate D (2003)- Psychiatry, religion and cognitive science. Aust N Z J Psychiatry, 37 (3): 277-85.
3. Hinterhuber H (2002)- The concept of soul in the course of history. Thoughts on psyche, mind and awareness. Wien Klin Wochenschr, 114 (19-20): 822-32.
4. Tori M (2001)- Shamanism: Traditional Practice vs. Modern Adaptation. http://www.metista.com/starrhawke/differences.html. Accessed May 15, 2003.
5. Cooper PC (2001)- The gap between: being and knowing in Zen, Buddhism and psychoanalysis. Am J Psychoanal, 61 (4): 341-62.
6. Whitehead CC (2002)- On the Asclepian spirit and the future of psychoanalysis. J Am Acad Psychoanal, 30 (1): 53-69.
7. Subramanium,S., Satyanarayana,M. & Rajeswari,K.R. (1986)- Alcoholism ; newer methods of management. Indian Journal of Physiology, Pharmacology, 30, 1-5.
8. Raina, N., Chakraborty, P.K., Basit, M.A. et al (2001)- Evaluation of yoga therapy in alcohol dependence. Indian Journal of Psychiatry, 43, 171-174.
9. Nespor K (1993)- Twelve years of experience with yoga in psychiatry. Int J Psychosom. 1993; 40(1-4): 105-7.
10. Bilu Y, Witztum E (1995)- Between sacred and medical realities: culturally sensitive therapy with Jewish ultra-orthodox patients. Sci Context, 8 (1): 159-73.
11. Tek C, Ulug B (2001)- Religiosity and religious obsessions in obsessive-compulsive disorder. Psychiatry Res, 104 (2): 99-108.
12. Davies MF, Griffin M, Vice S (2001)- Affective reactions to auditory hallucinations in psychotic, evangelical and control groups. Br J Clin Psychol, 40(Pt 4): 361-70.
13. Kozumplik O, Jukic V- Psychiatric patients' experiences in complementary and alternative medicine (CAM), and in religious support--a pilot study. Coll Antropol, 26 (1): 137-47.
14. Nelson CJ, Rosenfeld B, Breitbart W et al- Spirituality, religion, and depression in the terminally ill. Psychosomatics, 43 (3): 213-20.
15. Baetz M, Larson DB, Marcoux G et al (2002)- Canadian psychiatric inpatient religious commitment: an association with mental health. Can J Psychiatry, 47 (2): 159-66.
16. Garroutte EM, Goldberg J, Beals J et al (2003)- Spirituality and attempted suicide among American Indians. Soc Sci Med, 56 (7): 1571-9.
17. Kendler KS, Liu XQ, Gardner CO et al (2003)- Dimensions of religiosity and their relationship to lifetime psychiatry and substance use disorders. Am J Psychiatry, 160 (3): 496-503.

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