Spiritual And Religious Themes In Psychiatric Management: A Proposed 'Biopsychosocial' Model

S Chattopadhyay

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Abstract

Psychiatric treatment still remains a challenge. The hurdles in the treatment of the psychiatric illnesses are yet to be tackled by the inventions of newer molecules of psychiatric medicines and the social "taboo" related to mental illnesses are yet to be solved too. Amidst this crux of problems, the present article is a search of non-pharmacological agents as adjuvant to the modern psychiatric drugs as well as encourages involvement of the society at large to reduce the society-based taboo related to psychiatric issues. The article tries to extract the influence of "religion" and "spiritual" practices in the in the mental health through a Meta analysis and finally proposes a "biopsychosocial model" and its possible implementation in the present state of psychiatric practice.

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INTRODUCTION

A tendency of accounting the ‘spiritualism' and ‘religion' in the treatment of various diseases is an age-old practice in the developing countries. Encouragement and acceptance of such indigenous practices are thought to be due to sub-optimal medical facilities, high degree of illiteracy and some deep-rooted common beliefs. On the other hand in the developed countries, where such amenities are optimum, we can expect the contrast picture; but astonishingly, rising tendencies of religious and spiritual practices are seen there too. The boom of science, high quality formal education, medical facilities and industrialization could not stop the silent intrusion of spiritual and religious modes of therapies in the modernized West. Therefore, put together, the world scenario is a (?) gross usage of religious and spiritual practice in relation to one's health, especially the mental health. The present paper is very keen to evaluate some common practice and its utility that could be admixed with the modern psychiatric treatment (especially the pharmacotherapy) to render an overall firmness in it.

BACKGROUND

Retrospective studies of the ‘spiritual autobiography' of the holy saints of seventeenth century reviews a lot of conceptual changes in the spiritual themes translated into psychiatric idioms of nineteenth century (Leuder and Sharrock, 2002). Moreover, ancient themes, related to spiritualism and religious bias are changing its shape and texture leading to a new concept of spiritualism, mostly in acceptable terms to the ‘modern' worshipers. This change is never-ending and largely depends on the change of the social scenario. Let us take the example of the ‘shamanic practice'. Now a day, the shamanic practice is far away from the traditional shamanism and popularly known as neo-shaminism. In the traditional shamanism, the shamans travel to the state of ‘ecstasy' by virtue of the hallucinogens or by experiencing extreme stress and pain to the body and mind to achieve ecstasy (Tori, 2001). The practice of neo-shamanism uses the rhythmic noise of ‘biting drum' instead of hallucinogens or partaking the extreme physical or mental stress (Tori, 2001). Now the question comes, what are the reasons of such conversion (shamanism to neo-shamanism)? The possible answers are hallucinogen-use has got legal obstructions, overdosing may cause severe physical harm etc. Worshipping by adopting the path of extreme physical agony is also losing its charm to the traditional worshipers because of increased chance of irreversible physical damage and even death. So, the transition is likely from the ‘old' to the new concepts and the ‘neo' things are becoming more acceptable due to its feasibility for practice too.

It has been claimed that neo-shamanism has got some beneficiary role in modern psychiatric practice (psychological and emotional healing) (Tori, 2001), for example, 'Psychopomp' ("guiding the spirits of the dead to their resting places in the Other worlds") is a way for psychological healing (Tori, 2001).

CURRENT STATE OF KNOWLEDGE

THE ANTIQUE RELIGIOUS AND SPIRITUAL THEMES IN TODAY'S WORLD:

The age-old belief is that the person, practicing jumbo-mumbo or other enticing methods in front of a crowd has gained the super power of God who can help out one from mental or physical agonies. The practitioners of such methods are worshiped in the society and so they can play an active role for accessing the bottom of the iceberg. With proper training these persons can counsel the persons in need and bridge between the patients and the doctors, which was usually difficult for the prevailing social taboo in the society at large. Though, it is impossible to confirm at this stage whether such counseling are helpful or not but from the purview of the feelings in the society it is assumed that it may offer some kind of mental peace at least to the patient-parties and can open the door for the patient to get the required treatment by doctors. Isn't it a form of psychotherapy, although debatable issue? Probably on the basis of this realization, Torri (2001) hypothesized that neo-shamans could be able to enlighten one's soul by virtue of their 'God-gifted' powers and philosophies and thus guide the sufferers to a world of 'realm' and buffer the stress-induced-shock. Cooper (2001), on the other hand, displayed an interactive dynamics of 'Zen' Buddhist teachings of Hui-neng and in the 'psychoanalytic writing' of Wilfred Bion. The author tried to explain 'the human tendency to concretize experiential states engendered through meditation/or the psychoanalytic encounter'. Cooper also drew the 'symmetrical' and 'asymmetrical' perceptual modalities from the Matte-Blanco's explication to understand the 'fluid state' of the soul. Finally the author proposes that both the disciplines, especially in concern to 'the experiencing subject's momentary state of consciousness' creates the core theme for both the Zen and psychoanalysis. Likewise, Whitehead (2002) analyzed Asclepian myth for future psychoanalysis. Asclepian model incorporates a multi-modal approach linked to today's 'psychosomatic model'. The indigenousness of the Asclepian view could be intervened with the modern psychopharmacology that are now very common in the modern psychodynamic psychotherapy and therefore the author emphasized the increasing acceptance of the Asclepian view among the modern psychoanalysts.

SPIRITUAL AND RELIGIOUS BELIEFS IN PSYCHIATRIC PATIENTS:

Psychiatric patients often reflect religious feelings probably to cope with the morbidity. Studies have shown that PTSD (post traumatic stress disorder)-affected patients often rely on religious symbols those can manipulate and finally buffer the intensity of stress (Bilu and Witztum, 1995). Study of Tek and Ulung (2001) found that religious-minded OCD (obsessive compulsive disorder)-patients show religious-oriented obsessions than non-religious obsessions. Davies et al (2001) observed that religious-based delusional ideations and auditory hallucinations are extremely common in first-episode religious psychotic groups. Because religious beliefs are predominantly prevalent in the psychiatric group of patients, religious therapies could help patients suffering from affective disorder, anxiety disorder, and even schizophrenia who show more encouraging result out of such therapy than the affective and anxious patients (Kozumplik and Jukic, 2002). Religion practices can also alleviate the spiritual well being in terminally ill depressive patients (Nelson et al, 2002). So there are hopes.

RELIGION AND SPIRITUALISM: THE EMERGING CONCEPTS:

Baetz et al (2002), in a population study in a Canadian tertiary care psychiatric set up, observed that 'worship attenders' were suffering from less severe depressive episodes, shorter hospital stay, higher satisfaction related to their lives, and much lower rate of alcohol abuse compared to 'no or less worship attenders'. Astonishingly, they observed the emergence and the load of psychiatric morbidities were not at all related when the frequency of prayer is increased. Therefore, the authors postulated that 'religious commitments' and not mere 'prayer' in the psychiatric in-patients have significant role in the multitude of the illness.

Garroutte et al. (2003) conceived that spirituality could be a shock absorber in human-sufferings. The authors, in their duly constructed study found that 'cultural spirituality' decreased suicidal attempts among the American Indians. Further, they observed that commitment of the Christianity has got no role at all in reducing the rate of suicide.

Grabovac and Ganesan (2003) found evidences regarding the usefulness of religion and spirituality in the day-to-day

psychiatric practice. In an interview-based empirical study on the psychiatric residents, the authors felt that resident psychiatrists should be trained with the religion and spiritual issues for better coping to tackle the psychiatric patients.

In another interesting population-study, Kendler et al. (2003) analyzed the role of religiosity on the lifetime psychiatric prevalence (‘Internalizing factors') and substance abuse (‘Externalizing factors'). They found nine disorders those could be examined by personal interview and later evaluated by statistical regression method. Five of them are ‘internalizing', e.g. phobias, major depression, generalized anxiety disorders, panic disorders, and bulimia and the remaining four are ‘externalizing', e.g. nicotine, alcohol or other drug dependence and adult antisocial behavior. These authors also found that out seven factors, thankfulness to God, general religiosity, forgiveness, God as the judge, unvengefulness, social religiosity and involvement of God in odds are significantly associated with the psychiatric outcome. One factor (unvengefulness) was associated with the reduced outcome of ‘internalized factors'. Four factors (general religiosity, involvement of God, and forgiveness, God as the judge) were associated to be decreasing the load of ‘externalized factors'; and the remaining two (thankfulness and social religiosity) were associated with the relieve of both the ‘internalized' and ‘externalized' factors. However, the work of Kendler et al. was unable to show any aetiological link between religiosity and tentative risk of mental illness or drug abuse.

To find the possible aetiological link, Bathgate (2003) studied the conceptual-bridge between psychiatry (especially the psychotherapeutic approach) and religion or 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 flavor of the study. The author found that the psychobiology and the religious and spiritual concepts, related to the mental health ‘share a belief in the existence of a transcendent mind'. Hinterheuber (2002) also tried to bridge among 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) and therefore understanding psychiatry in the other hand is the understanding of one's soul.

It is becoming overt from the above studies that religion or spiritual modalities of therapies (may be learned by trainee psychiatrists or pastors) could be compassionate for the psychiatric patients, provided it follows the ethical commitments before being practiced; because 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 complications, Lomax et al. (2002) proposed ‘ethical considerations' in the psychotherapy integrated with religion. They observed that burden of ethical issues are far less in the spiritual psychotherapy compared to religious psychotherapy. The spiritual psychotherapy is consisted of personal attention, the nature of work he or she does, and ‘the pursuit of empathic understanding'. The authors conclude with suggestions that systematic spiritual assessment without violating one's religious right, integrating the spiritual and religious dimensions (a secular way) in patient's life and therapy, and formation of the modernized ‘biopsychosocial model' pertaining the highest amount of skill, knowledge, and attitude, spiritualism could be instituted as one of the therapies in mentally ill patients.

Hinduism is largely practiced in the Eastern World. It is claimed that Hindu philosophy and practices are significant contributors in making the personality. Hindu festivals are made for showering overwhelming joy through worshiping the images of the God or Goddess. It releases of stress due to complete submission of one's soul onto the feet of the God and then waiting for the next year with a lot of expectations to beget it as another shock-absorbing phenomena.

Regarding practicing meditation (Yoga) and its role in the mental health there are optimistic opinions. Subramanium et al (1986) and Raina et al (2001) in their well-documented studies showed that meditation is a potent healer, especially in chronic alcoholics. Nespor (1993) also found usefulness of yoga in the prevention and treatment of complications related to alcohol and drug dependence, in psychosomatic disorders, various neuroses, geriatric psychiatry, anxiety disorders and in other related areas.

CONCLUSIONS

STRATEGIES MAY BE TAKEN FOR THERAPEUTIC PERSPECTIVE:

- Training of parents, care-givers of the mentally ill patients for deploying spiritual support to their brothers and sisters in need,
- Training primary health care staff i.e. doctors and nurses from their undergraduate and even postgraduate training how to adopt and practice spiritual therapy to the patients,

- Training priests, pastors, local leaders how to deal and assist doctors in the treatment of mentally ill patients and their family members,
- Founding therapeutic-cum-counseling set up in the temple or mosque or monastery or in the church,
- Deploy the religious view of comprehensive model of illness and coping,
- Establishing necessary cooperation with counselor / pastor,
- Psychological education: making people aware that religious life can be affected by mental illness and distress (e.g. depression) so it is advised to get rid of it by the help of the best and rational treatment, available,
- Ascertain functional and dysfunctional aspects of religious interpretation,
- Value-related therapy: using references from the holy books without losing insight of the bio-psycho-social aspects of psychopathology and modern medicines.

WHAT COULD BE THE TENTATIVE METHODOLOGIES?

1. Traditional: Confession, prayer, communion, blessings through ‘laying of hands', showering holy water etc.,
2. Transitional protecting objects: Pictures of saints, Amulets, Holy Cross, protecting objects etc. are thought to be protective against the evil power and could be placed in the counseling or treatment center,
3. Encouragement of religious activities: Arranging and participating religious festivals, pilgrimage, religious exercises, visiting saints as the special healers etc.,
4. Counseling: Imagery, prophecy, deliverance, rebuking demons etc. could be other models, could be adopted to treat mentally ill patients.
5. Yoga (Meditation): (1) Asanas: Shavasana (5min), Bhujangasana (2 min), Dhanurasana (2 min), Paschimothanasana (2 min), Sarvangasana (2 min), Chakrasana (2 min). (2) Pranayama (5 min) (3) Yoganidra (20 min)As recommended by Raina et al (2001),
6. Medical Attention: Instituting pharmacological agents in the name of God's ‘prescription' or advice to prevent treatment dropout.

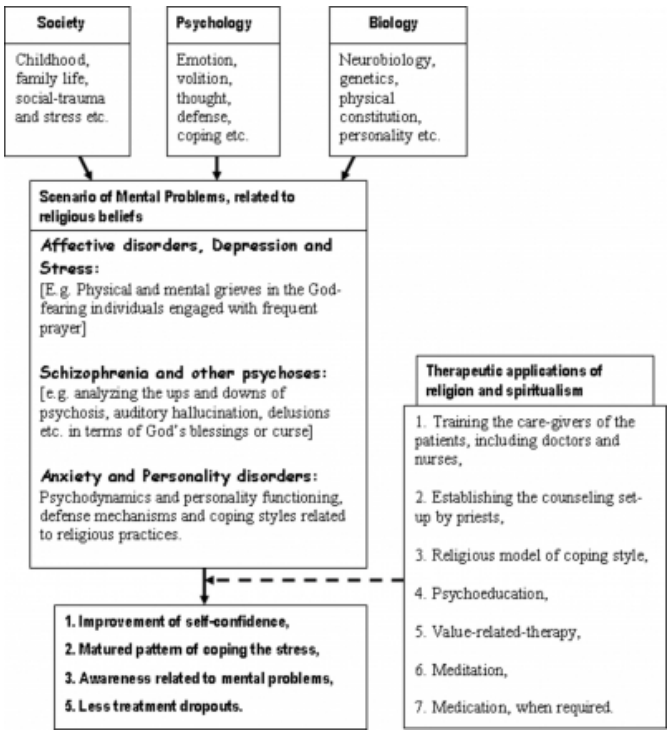
EXPECTED OUTCOME

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

1. Improvement of self-confidence (based on confidence on God),
2. Enabling people to develop matured pattern of relating to the environment,
3. Enhancement of coping with the Life's increasing demand,
4. Preservation of the awareness and the awe of the ultimate spiritual reality, God.
5. Less treatment dropouts because of the notion that pills, prescribed by the doctors (trained how to deal their patients spiritually) are god-gifted so he/she must not dishonor the so-called serenity of the pills.

Figure 1

Model 1 (Biopsychosocial model in religious and spiritual practice in psychiatry)



FUTURE RESEARCH PROPOSALS

A. The acclaimed benefits of the neo-shamanism, various ways of worshiping the God in different religions, spiritual psychotherapy etc., discussed on the foreground of the article are still hypotheses. The studies are based principally on the cause-effect relationship without valid documentation of biological implications and changes in one's body and brain. Therefore, the article proposes detail neurophysiological research to evaluate the biological basis of such improvement.

B. Further, the present article proposes to include the age at onset, age at first symptoms, age at first hospitalizations, gender, ethnicity, immigration, familial background, available socioeconomic support, and cultural concepts as important variables for a more defined and refined epidemiological research related to the influence of religion and spiritualism in one's mental health.

CORRESPONDENCE TO

Subhagata Chattopadhyay B-166, IIT KGP, KGP-721302, W.B. INDIA. Telephone: 91 [03222] 277054. E-Mail: subhagatachatterjee@yahoo.com

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Author Information

Subhagata Chattopadhyay
Medical Officer, B. C Roy Technology Hospital, Indian Institute of Technology