

# Psyche and Spirit: connecting psychiatry and spirituality

Newsletter of the Section on Religion, Spirituality & Psychiatry

Vol. 3 Issue 1 February 2014

Editorial Board: Alexander Moreira-Almeida, Simon Dein, and Peter J. Verhagen

[www.religionandpsychiatry.com](http://www.religionandpsychiatry.com)



WORLD PSYCHIATRIC ASSOCIATION

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## Editorial

We are very pleased in presenting to you the fifth issue of "Psyche & Spirit". The wide range of topics, approaches and geographical distribution of contributors reflects the vigor and advance of the field and of the Section on Religion, Spirituality & Psychiatry. This issue presents news on recent developments in

Jordan and in Brazil, where the national psychiatric association has just created a section of spirituality and psychiatry. Studies on neuroimaging, epidemiology and clinical applications are presented and discussed. The WPA Section on Philosophy collaborates with a paper on their perspectives on spirituality and psychiatry. Also reflecting field's vitality, we announce three events, including the World Congress of Psychiatry that, until now, has approved six symposia on Religion, Spirituality and Psychiatry, involving authors from nine countries and four continents. In order to keep all this auspicious flourishing, Section's elections are coming.

We wish you a pleasant and fruitful reading! The Section warmly welcomes contributions of colleagues from all over the globe and from all spiritual and philosophical backgrounds. Join us!

## News

### SECTION'S ELECTION

The WPA Section on Religion, Spirituality and Psychiatry is making all necessary preparations in order to call Section elections for the Section officers (chair, co-chair and secretary) and board members. It is our aim to declare the results during a special section meeting at the WPA World Congress in Madrid next September. All members on our mailing list will be informed about the ins and outs of these elections and invited to vote. Members who want to stand a post should make their candidature known to both the chair and the secretary of the Section, Peter J. Verhagen and Dr. Nahla Nagy, by e-mail: [p.verhagen@ggzcentraal.nl](mailto:p.verhagen@ggzcentraal.nl), [nahlanagy64@yahoo.com](mailto:nahlanagy64@yahoo.com)

The Section board appreciates your interest and support in this important process!

## **CREATION OF THE SECTION ON SPIRITUALITY AND MENTAL HEALTH AT THE BRAZILIAN PSYCHIATRIC ASSOCIATION**

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In Brazil, nearly 90% of the population considers religion very important in their lives and more than one third of people attend a religious service at least once a week (Moreira-Almeida et al., 2010). Some Brazilian universities have already addressed this issue in undergraduate medical courses, as well as in post-graduate. Moreover, a large number of theses and dissertations have been defended or are ongoing in the country (Lucchetti et al, 2012a). Brazilian psychiatric community has shown interest in religiosity and spirituality by the presence in activities on the topic in recent Brazilian Congresses of the Brazilian Psychiatric Association, the publication of books on the subject (Dalgalarondo, 2008; Moreira-Almeida & Santos, 2012), the high citations of articles published on the topic in the journals RBP Psychiatry (Revista Brasileira de Psiquiatria) (Rev Bras Psiq 28:242-50, 2006 e 26: 82-90, 2004) and Revista de Psiquiatria Clínica (37:12-5, 2010 e 34 - supl. 1:95-104, 2007), well as the large number of accesses to the SciELO special issue on spirituality and health of the Revista de Psiquiatria Clínica (over 270,000 hits). However, although patients, doctors and directors of medical schools consider important that the religiosity/spirituality is addressed in clinical practice, national and international studies show that this approach is not common and doctors feel unprepared to do that due to the large deficiency of training and knowledge on the topic (Mariotti et al., 2011; Lucchetti et al., 2011, 2012b).

Thus, a group of members of the Brazilian Psychiatric Association proposed the creation of a group that could work with the theme religiosity/spirituality in the organization. Then, in early 2014, the Brazilian Psychiatric Association officially approved the

establishment of the Commission for the Study and Research on Spirituality and Mental Health, like in the World Psychiatric Association, American Psychiatric Association and Royal College of Psychiatrists, institutions that already have departments and sections dedicated to this area of knowledge.

The opening request for the Commission received strong support from the Brazilian psychiatric academic community, having, as signatories, professionals from 23 different research groups and from different regions of the country. Moreover, the proposed creation of the Commission also had the institutional support of other psychiatric entities such as the Executive Committee of the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists, the World Psychiatric Association Section on Religion, Spirituality and Psychiatry, the American Psychiatric Association's Caucus on Spirituality, Religion and Psychiatry.

The coordinator of the Brazilian Commission is Prof. Alexander Moreira-Almeida, who is also member of the World Psychiatric Association Section on Religion, Spirituality and Psychiatry Board. Prof. Homero Vallada and Prof. Quirino Cordeiro will also take part of the Board of the Commission for the Study and Research on Spirituality and Mental Health.

In February of this year, in Rio de Janeiro/Brazil, the Brazilian Psychiatric Association has organized the strategic planning meeting of its new directive group. On occasion, the Commission for the Study and Research on Spirituality and Mental Health presented their work plan for the next triennium. Multiple work proposals were presented and planned. The Commission has proposed different activities for the next Brazilian Congress of Psychiatry, which is the third largest psychiatric event in the world, with about 6,000 participants. For the first time, religiosity/spirituality will be considered a thematic area of the Brazilian Congress of Psychiatry. So, for example, researchers can submit their works for presentation in this specific area during the Congress. Two round-tables talks are being organized for the Congress, one being about clinical aspects of religiosity/spirituality and another about research issues. A pre-course is also being

prepared on the subject and will focus essentially on the clinical aspects of the theme, helping the psychiatrists handle this subject in a better way. Moreover, the 2014 Brazilian Congress of Psychiatry will be attended by Prof. Dan G. Blazer, who is Professor of Psychiatry and Behavioral Sciences and Professor of Community and Family Medicine at the Duke University School of Medicine. The Commission will be in charge for his activities during the Brazilian Congress.

In 2014, the Commission for the Study and Research on Spirituality and Mental Health will also be responsible for preparing a course of continuing education for members of the Brazilian Psychiatric Association about religiosity/spirituality. This course will be available at the website of the Association for its members.

In order to take part of the international scenario in the field, the Commission will organize the Global Meeting in Spirituality and Mental Health, in 2015. The objective is to bring to Brazil the leading researchers in the area of religiosity/spirituality and mental health, and at the end of the event, the keynote speeches can turn into a book on the topic. The aim is to create a reference publication in Portuguese in the field for Brazilian psychiatrists.

The Commission is also interested in fostering research. Thus, initially the Commission proposed to the Brazilian Psychiatric Association an extensive research with Brazilian psychiatrists in order to assess how they work the issues of religiosity/spirituality in their clinical practice as well as in their own lives. The results of this research will help the Commission to organize their activities dedicated to the Brazilian psychiatrists.

Aiming to be close to the community of Brazilian psychiatrists, the Commission will create a website and a discussion group on the internet about various subjects related to religiosity/spirituality and mental health.

With these initiatives, the Brazilian Psychiatric Association, undoubtedly opens a large institutional space for subjects related to religiosity/spirituality,

bringing to the Brazilian psychiatrists an assess to this area of knowledge in a scientific and technical way, thereby contributing to the improvement of this field in Brazil. Therefore, professionals and patients can be benefited.

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## Why existential issues need to be addressed in clinical practice: a conceptual analysis

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### Introduction

Addressing existential issues can hardly be legitimized when psychiatric practice is based on a predominantly biomedical approach to mental disorder. Daily practice shows that patients often have existential concerns. A conceptual model is needed to do justice to this observation and to show how existential issues can legitimately be addressed in psychiatric practice. This poster sketches a possible model (see diagram).

### Definitions

Existential issue = an issue which expresses something fundamental about a person's existence (examples of existential issues: death, freedom, individuality, meaning). Existential themes usually emerge from a person's attitude, and they concern the 'whole self' (both in time and qua mode of being)

Existential themes may become objects of emotion and/or reflection; however, only secondarily; they primarily reflect a form of self-relatedness.

### Conceptual analysis of the relationship between psychiatrist, patient, disorder, and 'self'

There are *four relationships*:

- (1) analysis of the clinical syndrome by the psychiatrist
- (2) investigation of the way the patient relates to her condition
- (3) analysis of the way the psychiatric condition affects this latter relation (example: demoralization as

depressive symptom affects the way the patient relates to her depression)

(4) 'who one is' (personality; strengths, vulnerabilities) affects the way the patient deals with her clinical condition → existential dimension

And there is *self-referentiality*:

(A) The emotion/mood/impulse refers to an aspect of one's self

(B) How one relates to this emotion/mood/impulse also reveals something about oneself; and: 'the' self influences the way the patient relates to his condition.

### Case vignettes

(1) A 33yr old woman with OCD and borderline personality disorder tells that from early childhood she has an overwhelming feeling of vulnerability and helplessness ("it is life itself that frightens me")

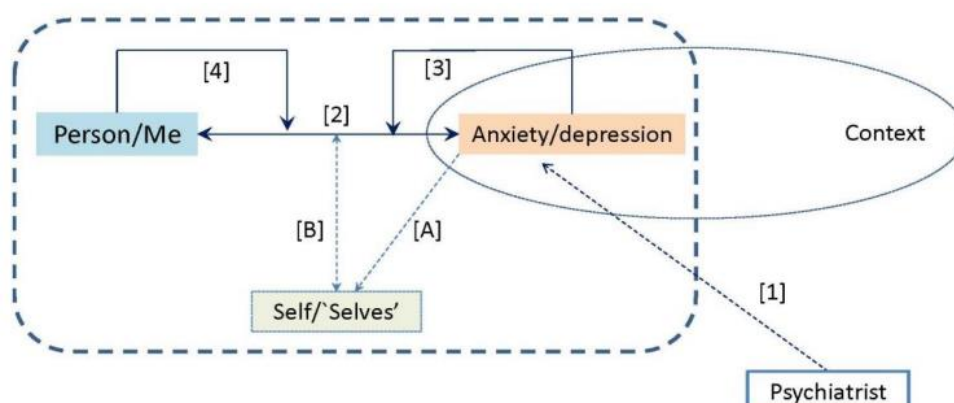
(2) A 46yr old man with chronic depression says he has always felt unable to connect with others because of a fundamental sense of isolation.

### Conclusions

- (1) Addressing existential themes is a matter of professionalism
- (2) Paying attention to existential themes is consonant with other approaches: 'values-based medicine'; 'recovery-oriented' approaches; self-management; acceptance/commitment therapy (a.o.).
- (3) Residents' curricula should pay attention to the existential dimension in treatment.

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## Comments

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We are grateful that professor Gerrit Glas, philosopher and psychiatrist, allowed us to publish his poster concerning existential issues in clinical practice presented at the 21st European Congress of Psychiatry, April 2013 in this issue of *Psyche & Spirit*. I would like to add a short explanatory note.

The attractiveness of his approach is the conceptual analysis of the attitude of the patient toward his illness, which parallels the conceptual analysis of the attitude of the psychiatrist toward his professional role.

The model differentiates the attitude toward illness in several components. Not only does the patient relate to his disorder, the disorder itself effects the relation of the patient to the disorder. And the patient as a person effects that relation. Take for instance a depressed patient. In psychiatric assessment we look for the attitude of the patient toward his illness in terms of insight and awareness of illness (2). The depression might influence this attitude by causing demoralization or a sense of inefficacy (3). Who the patient is as a person, his personality (virtues and vices), strengths, vulnerabilities, his motivations and convictions, influence the way the patient reflects on and deals with the illness (4). For instance the patient might have the conviction based on his personal views that in case of psychiatric illness belief in own strength should prevail over or even contradicts the use of any medication.

It is interesting to note that this approach and analysis is partly based on Jaspers' concept of the patient's attitude toward his illness. Jaspers approach can be found in his 'General Psychopathology' (Jaspers, 1973/1997, Part 2, chapter 7). Seen this way it becomes very obvious that the psychiatrist should not confine himself to the assessment of the illness only (e.g. depression) (1), but should take into account the full picture of the way the patient relates to the illness.

Interesting enough, parallel with this approach of the attitude of the patient toward his illness something similar could be said regarding the relation of the professional to his professional role. The professional relates to his professional role, this role effects this relation, as the person (including virtues and vices, moral and life views) of the professional does. Reflecting on this is certainly an aspect of professional competence. In both cases therefore the person comes into view, including his and her personal existential, religious or spiritual views. In fact one cannot abstract from either of these relations, not in the patient's case and not in the professional's case (Glas, 2012). Such an approach is obviously consonant with other person-centered approaches in psychiatry and medicine in general. Recently, among others, Gabbard et al. have made it clear again that psychiatrists and other mental health professionals are involved in "values-based decisions of profound importance in the lives of patients" (Gabbard et al, 2012). The conceptual analysis offered by Glas does help us to understand that there is, often beneath the surface, always an existential element that influences how the professional relates to his role, and that to the extent the professional is better able to deal with this element the better he will be able to address the existential issues in what the patient has to tell about himself and his attitude toward his illness.

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## Jordan and Religions

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Jordan is an Arab, Muslim Middle Eastern country by the name of Hashemite kingdom of Jordan, the Hashemite being the descendants of Prophet Mohammad (peace be upon him), while river Jordan is associated with Christianity, Jordan is 92 thousand sq. Kilometer with a population of six million.

The Middle East is a poorly defined region that roughly encompasses majority of Western Asia and Egypt. The term is used as a synonym for Near East, in opposition to Far East; North Africa is the other part of the Arab world. The largest ethnic group in the Middle East is Arabs with Turks, Turkomans, Persians, Kurds, Azeris, Copts, Jews, Assyrians, Maronites, Circassians, Somalis, Armenians, Druze and numerous additional minor ethnic groups forming other significant populations. The term Muslim world has several meanings in a modern geopolitical sense, the term Islamic usually refers collectively to Muslim-majority countries, states, districts, or towns. As of 2010, over 1.6 billion or about 23.4% of the world population are Muslims. Of these, around 62% live in Asia-Pacific, 20% in the Middle East-North Africa, 15% in Sub-Saharan Africa, around 3% in Europe, and 0.3% in the Americas.

The country's health care system is divided between public and private institutions. In the public sector, the Ministry of Health operates 1,245 primary health-care centers and 27 hospitals, accounting for 37% of all hospital beds in the country; the military's Royal Medical Services runs 11 hospitals, providing 24% of all beds; and the Jordan University Hospital accounts for 3% of total beds in the country. The private sector provides 36% of all hospital beds, distributed among 56 hospitals. Psychiatric services follows the same track there are 3 hospitals run by the ministry of health ,one by Royal Medical Services and one private hospital with out- patient facilities of the three sectors, Health expenditure is 8.4% of GDP (2011) with 2.56 physicians/1,000 population (2010), Jordan is a constitutional monarchy. Jordan is classified as a country of "medium human development "by the 2011 Human Development Report, and an emerging market with the third freest economy in West Asia and North Africa (32nd freest worldwide). Jordan has an "upper middle income" economy. Jordan has enjoyed

"advanced status" with the European Union since December 2010, and it is a member of the Euro-Mediterranean free trade area. It is also a founding member of the Arab League and the Organization of Islamic Cooperation.

Psychiatry in Jordan is active, Amman has been the center of Arab Journal of Psychiatry since 1989, which is the official journal of the Arab Federation of Psychiatrists and it is free online ([www.arabjpsychiat.com](http://www.arabjpsychiat.com)) The journal reflects the Arab world mental health with its cultural flavor and religious depth, being Islamic and Arabic are closely associated.

Jordan has received refugees over the decades, and over the last 3 years has received Syrian refugees, they have been our guests, the mental health needs are enormous, with very limited resources, but many regional and international NGOs are working with the refugees, over the years Jordan has been affected by the turmoil of the Middle East, people with war trauma have always found help in Jordan.

The Association of Jordanian psychiatrists has been around more than 3 decades with less than fifty psychiatrists, the association is keeping active and involved in local, regional and international activities, the upcoming conference 4 – 6 of June 2014, is the third regular international Jordanian conference ([www.eventscons.com](http://www.eventscons.com)) with the theme Mental health of refugees, it is co – sponsored activity of WPA and the Arab Federation of Psychiatrists, with guest speakers from different parts of the world.

Psychiatric practice normally has religious and spiritual aspects all through the time ,as religion is part of our lives and gets more significant it case of illness and particularly in psychiatric disorders, patients usually seek the help of healers mainly those with religious titles(sheikh).

Psychiatry on top of the list of attractive specialties that bring Arab Patients to Jordan for treatment and accordingly the practice of psychiatry in Jordan is regional in nature.

The religious tourism is another source of income, as Jordan has been blessed with a rich religious history, it is located between Mecca al-Mukarrama, the holiest place on earth for Muslims, and al-Quds (Jerusalem), which is sacred to each of the three great monotheistic religions, Jordan has played a central role in the history of the ahl al-Kitab (People of the Book Jews and Christians).

The land around the Jordan River Valley and the Dead Sea is considered by Muslims, Christians and Jews as blessed. The Bible calls it "the Garden of the Lord" (Genesis 13: 10), and the Holy Qur'an says that God blessed the land "for all beings." Indeed, half of humanity views the land and the river of Jordan as the geographic and spiritual heartland of their faith.

The southern Jordan River Valley, the Dead Sea plains, and the surrounding hills and mountains are the home for some of the most momentous events in the history of man's relationship with God. Here Prophet Ibrahim (Abraham) arrived in the Holy Land, Jacob and Esau made their pact, God protected Lot while destroying Sodom and Gomorrah, Moses saw the promised land which he would never enter, Joshua crossed the Jordan River into Canaan, Elijah crossed the Jordan River and rode a "chariot of fire" into heaven, Elisha cured the leper in the waters of the river, John the Baptist preached, baptized Jesus, and was killed by King Herod, Jesus received the Holy Spirit and resisted the temptations of Satan, and the Prophet Muhammad made his nighttime journey from Mecca to al-Quds (Jerusalem).

Jordan is attractive for religious pilgrims from throughout the world to rekindle their faith and commitment to God by visiting the land and river that have inspired prophets and formed the geographic and spiritual backdrop for God's covenants with mankind. Many of the sites of biblical events and miracles have been identified, protected and made easily accessible to visitors. The eastern banks of the Jordan River are home to no fewer than 100 sites of biblical importance. From Abraham and Moses to John the Baptist and Jesus Christ, the founding fathers of the three

monotheistic traditions are all intimately tied to the Jordanian landscape.

## WPA'S SECTIONS VIEWS ON SPIRITUALITY Philosophy and Humanities in Psychiatry

### Philosophical issues on spirituality and religion in psychiatric practice: when reasonable concerns turn into overreaction

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Religion and spirituality are integral to the lives of many patients and that alone suffices to recommend that psychiatrists pay attention to them in the clinical setting. For many patients, however, the relevance of religion and spirituality stands out when compared to various other aspects of their lives. Indeed, religiosity and spirituality often comprise more than mere mental contents or practical life domains. Instead, even at a strictly psychological level, they constitute very broad and dynamic networks of intertwined cognitive, affective and behavioral aspects that, beyond their inherent complexity, also interact with and play a major role in modulating other life domains. This includes framing the way these patients relate to other people, setting behavioral limits, orienting goals and projects, providing meaning to life, a sense transcendence, as well as guidance in times of suffering. Getting to know and understanding religious or spiritualized patients, therefore, requires psychiatrists to give special attention to a wide array of variables, many of which are at the core of patients' identities. This is a task that may require special knowledge and skill from the clinician, thus justifying the need for a place for this topic in psychiatric curricula (Culliford, 2002).

While claims on the potential harmfulness of religion and spirituality have a lot of appeal, there is an increasing amount of data supporting their positive effect on mental health (Koenig, 2001). Still, the debate persists as to whether, how and the extent to which

religion and spirituality fit together with clinical psychiatry. Should religion and spirituality be addressed in the inquiries that aim at understanding the patients, but simply left untouched thereafter? Should the suffering related to spiritual and religious issues be dealt with by using the tools of psychiatry and the treatment of mental disorders be aided by religious and spiritual guidance? Certainly, part of the concerns as to how should psychiatrists proceed in this regard is practical. However, some uneasiness and resistance of psychiatry against religion and spirituality may also arise from philosophical considerations. Some of the arguments that may eventually be raised will be briefly commented in the following. The point will be made that the philosophical concerns presented do not provide legitimate basis for mutual segregation of those fields.

### **Metaphysical concerns**

Because the truth of religious beliefs and mystical experiences is so elusive to ascertain, questions may arise as regards to how wise it actually is the approximation between psychiatry and spirituality. In particular, it may be feared that this move would present psychiatrists more often with situations in which the suffering and undesirable behaviors of patients are intertwined with their metaphysical beliefs and mystical experiences, thus bringing up clinical conundrums that would remain for as much time as psychiatry itself avoids embracing a position on the subject. Metaphysical aspects of spirituality and religion, however, should not discourage psychiatrists from recognizing that there is a place for them in clinical practice. While of interest to theologians and philosophers, speculation on the truth of the metaphysical beliefs held by patients should not actually concern psychiatrists more than the truth of other beliefs patients have.

Surely, for many patients spirituality is simply devoid of mystical or theological underpinnings. But even when there are metaphysical assumptions at the core of the spirituality of the patients, and these happen to be intrinsically related to why someone is under psychiatric attention, it is arguable that they pose

special challenge to diagnosis and interventions. Arguing that the mystical beliefs held by patients are elusive to validation or falsification and, because of that, psychiatry and spirituality should be kept apart, misses the actual target. In fact, what is at stake in every case is not whether some content is elusive to demonstration, but whether the phenomenon it is pathological or not. As it happens, whether they have a mystical outlook or not, pathological beliefs, experiences or behaviors will hardly be identified as such solely on the basis of their content. A host of other clinical features, contextual variables and characteristics of the patient's spirituality may assist the diagnosis (Menezes Jr, Moreira-Almeida, 2010). Of course, this is not to say that the distinction between mystical experiences and psychiatric disorders is straightforward and that there is no gray zone between the two. Instead, what is meant here is that the approaches through which psychiatrists attempt to distinguish between pathological and true mystical experiences are similar to those employed to classify other experiences whose contents are also evaluative or elusive to falsification. In a sense, then, this is less of a problem presented to psychiatry by religion than a vicissitude of psychiatric diagnosis.

### **Epistemological and ethical concerns**

Epistemological and ethical concerns as regards the relationship between psychiatry and religion have been thoroughly discussed by Fulford (1996). While the point raised in the topic above is in the crossroad between metaphysics and epistemology, at a more strictly epistemological level there may be found the concern that psychiatry, as a scientific discipline, deals with objects that are different from those dealt with by spirituality and religion, also adopting a distinct approach. While it is sometimes argued that science and psychiatry have their interests driven to what is tangible and observable, and that this is done with freedom from presupposition and an objective approach, religion and spirituality are blamed to do rather the opposite. What arguably follows is the fear that psychiatry would be at risk of becoming incoherent with its aims and of losing its scientific grip if spiritual matters were brought in.



However, not only psychiatry is concerned with issues that are far from objective, like values and subjective experience, but science as a whole is everything but free from presuppositions and unbiased. Besides the fact that perspective is always involved in the apprehension of facts, the very choice of theories to account for these facts arguably reflects preferences.

Another source of uneasiness when it comes to psychiatry embracing religion is the moral aspect of the latter. In part as a reaction against being labeled as a moral discipline by the anti-psychiatric movement, psychiatry has turned itself even more towards a mechanistic view of the human mind — typical of the biomedical model — that leaves out freedom of will. And because guilty and the implied punishment are ideas enmeshed in the way religions are taken to guide the behaviors of believers, psychiatry has arguably found an additional reason to stay away from it. Of course, by choosing to keep religion apart, psychiatry does not provide a valid rebuttal to its own value-ladenness. That is, avoiding an approximation with religion at best counts as a statement of principles or a paradigm choice, leaving untouched the most relevant issue: does psychiatry itself include moral aspects? The answer is clearly yes, for dealing with behaviors and experiences that belong to persons, psychiatry is inevitable evaluative to a certain extent. That implies that not only psychiatry may be avoiding approximation on religion on the basis of a wrong rationale, but also that, by trying to adopt a makeup that is opposite to that of religion, psychiatry is at risky to neglect crucial aspects of its object of interest.

As pointed out by Fulford (1996), the polarizations described above — between a psychiatry that intends scientific objectivity and moral neutrality, and a psychiatry that is argued to be as value-laden and subjective as law and religion — certainly dissipate any ethical or epistemological tension concerning the relationship between psychiatry, religion and spirituality. For each of the described views on psychiatry, it emerges crystal clear the appropriate attitude towards religion and spirituality. Either the divide is kept (and even reinforced), or they are essentially equated. In this case, however, the cure

seems worse than the disease. Whereas by leaving context and subjective aside psychiatry loses its object, by fully embracing subjectivity it is at high risk to wander adrift, influenced mainly by personal opinions. Because psychiatry is simultaneously about facts and values, any of the reductionist approaches described would impoverish the field.

### **Final remarks**

Psychiatry is not an easy field and bringing it closer together with religion and spirituality certainly deserves cautious examination of the tools adopted and the likely consequences. Examining the issue from a philosophical perspective is a critical step. While metaphysics does not seem to pose a problem in itself, it engenders clinical challenges that, nonetheless, are not in any way special. That is, to diagnose and intervene when mystical experiences are part of the clinical picture is not harder because of the metaphysical assumptions of the patient but, if at all, it is hard because diagnosis is a troublesome issue in psychiatry and because there is still need for well-established models of partnership between psychiatrist and clergy. As regards epistemological and ethical concerns, psychiatry must face its fate. Because it deals with objects that are both factual and evaluative, it will always make us deal with very complex situations, from both practical and theoretical points of view. Trying to avoid it — and this includes keeping away from religion and spirituality — gives rise to an even worse outcome, as the field itself is distorted..

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## Research corner

### Religious/spiritual beliefs and neuroimaging studies: pursuing biological pathways

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In the last decades, a special attention has been given to the studies dealing with behavior and neuroimaging (1). At the same time, there has been criticisms that studies on spirituality and religiousness are based on self-report measures subjected to several ways of bias (2).

Within this context, many authors are trying to understand whether faith can change brain connection and even brain structures (3). These biological markers could give further evidence to this field of research and show mechanisms by which R/E could lead to beneficial or detrimental outcomes.

Based on these assumptions, Miller and colleagues(4) conducted an interesting study which has been published in *JAMA Psychiatry*. Through a longitudinal study of 103 adults, they found importance of religion or spirituality, but not frequency of attendance, was associated with thicker cortices in the left and right parietal and occipital regions, the mesial frontal lobe of the right hemisphere, and the cuneus and precuneus in the left hemisphere. In addition, the effects of importance on cortical thickness were significantly stronger in the high-risk than in the low-risk group, particularly along the mesial wall of the left hemisphere. They concluded that a thicker cortex associated with a high importance of religion or spirituality may confer resilience to the development of depressive illness in individuals at high familial risk for major depression.

In the same line, another study carried out by Owen and colleagues(5) examined relationships between religious factors and hippocampal volume change using MRI data of a prospective sample of 268 older adults.

They observed greater hippocampal atrophy for participants reporting a life-changing religious experience. Significantly greater hippocampal atrophy was also observed from baseline to final assessment among those who found religion late ("born-again") Protestants, Catholics, and those with no religious affiliation, compared with Protestants not identifying as "born-again". According to the authors, these findings may reflect potential cumulative stress associated with being a member of a religious minority, or being someone who struggle with their beliefs.

The same group(6) has also investigated the association between religious or spiritual factors and volume of the orbitalfrontal cortex (OFC). Authors observed less atrophy of the left OFC in participants who reported a life-changing religious or spiritual experience during the course of the study, and in members of Protestant religious groups who reported being "born-again" when entering the study. Significantly greater atrophy of the left OFC was also associated with more frequent participation in public religious worship. No significant relationship was observed between religious or spiritual factors and extent of atrophy in the right OFC.

Additionally, Kapogiannis et al.(7) have investigated 40 healthy adult participants who reported different degrees and patterns of religiosity through structural MRI. They found that experiencing an intimate relationship with God and engaging in religious behavior was associated with increased volume of Right middle temporal cortex. Experiencing fear of God was associated with decreased volume of Left precuneus and Left orbitofrontal cortex. According to the authors: "religious beliefs and behavior emerged not as sui generis evolutionary adaptations, but as an extension (some would say "by product") of social cognition and behavior".

Finally, in a study carried out by Beauregard and Paquette(8) measuring Carmelite nuns while they were subjectively in a state of union with God, found significant loci of activation in the right medial orbitofrontal cortex, right middle temporal cortex, right inferior and superior parietal lobules, right caudate, left medial prefrontal cortex, left anterior cingulate cortex, left inferior parietal lobule, left insula,

left caudate, and left brainstem. Other loci of activation were seen in the extra-striate visual cortex. These results suggest that mystical experiences are mediated by several brain regions and systems.

All these results are far from conclusive. It seems that both sides of religiousness and spirituality are important and can modify our brain structure. The positive side of R/E (comfort, well being, positive coping, resilience) may increase and stimulate cerebral areas. On the other hand, the negative side of R/E (religious struggle, punishing God and feelings of abandonment by God) may decrease certain cerebral areas.

In conclusion, these studies reveal we still know little about our brain, and almost nothing about our religious and spiritual experiences and their biological pathways. More longitudinal studies in this area and their clinical implications are welcome.

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#### Bookmarker<sup>1</sup>

Peter J. Verhagen

Prof. dr. Arjan Braam<sup>2</sup> and his colleagues publish regularly interesting and important data and results based on LASA (Longitudinal Aging Study Amsterdam), an ongoing interdisciplinary study on predictors and consequences of changes in autonomy and well-being in an aging population. Braam pays especially attention to religiosity and depression; several of his studies are listed in Harold Koenig's canon of empirical studies on religion and (mental) health (2012). Good reasons therefore for reviewing his latest study in this heading of the Newsletter.

This newest paper is published in *The American Journal of Geriatric Psychiatry* (Braam et al. in press). I would like to highlight a few interesting points in this study. It is known that late-life depression and religiousness are interrelated in several ways. This study concentrates on depression and the emotional aspects of religiousness. An important approach since studies on emotional aspects of religiousness and depression are scarce. From a psychodynamic perspective one way to conceptualize these religious feelings or emotions is to focus on the perceived object relationship with God. The God representation (God image) pertains to a special type of object relationships. In this study the focus is on association patterns for history of late-life depression with subsequent feelings about God and religious coping strategies.

From the original sample of 3805 respondents in 1992, a subsample of 496 respondents (aged 63-93 years) in 2005 took part in the current study, leaving for several reasons a study sample of 343 respondents. Depression symptoms, history of depression feelings about God and religious coping were assessed. Investigation of feelings or emotions about God is clearly a quite new element in this type of study. A Questionnaire on God Image (QGI) is available. The QGI comprises a set of scales, which distinguish two

dimensions: feelings about God (positive feelings, fear of God and feeling wronged by God) and perception of God's actions. In this study only the feelings about God dimension was used.

Conclusions; The depressions trajectories characterized by more persistent and concurrent symptoms showed clear associations with fear of God and feeling wronged by God as well as with negative religious coping. Most illustrative items in the association between depression and feelings about god are: uncertainty towards God, expressing feelings of desolation, and the interpretation that one has been abandoned. And, as has been found in previous studies, the strength of the association between negative feelings about God and negative coping is unusually strong. On the one hand negative coping may add to a vulnerability to depressions, on the other hand depressive states might exert a scarring effect, leading to a negative emotional attitude to religion (disillusionment with religion). The authors explain how these results could be interpreted from a psychodynamic perspective (loss of a loved object) and Kirkpatrick's application of attachment theory to the psychology of religion, and from a cognitive point of view (dysfunctional core beliefs, which may parallel a tendency to devalue oneself and therefore impair affective functioning).

The authors state: 'The current study suggests that the emotional aspects of religiousness seem to have a pervasive relationship with a vulnerability to depression. From a clinical point of view and based on empiric research, inquiries into the desolation experience, for example, might be recommended. Discussing existential dilemmas alike might touch on compelling experiences, at least for some depressive patients' (emphasis added, PJV). Since longitudinal findings on religious emotions and (not only) depression are relatively rare a lot of work is still to be done!

Braam, A.J., Schaap-Jonker, H., Horst, M.H.L. van der, Steunenbergh, B., Beekman, A.T.F., Tilburg, W. van, Deeg, D.J.H. (in press). Twelve-Year History of Late-life Depression and Subsequent Feelings to God. *The American Journal of Geriatric Psychiatry*. Published

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<sup>1</sup>In this heading a new and interesting research paper is briefly reviewed (600-700 words). Readers are invited to contribute to this heading.

<sup>2</sup>Prof. dr. Braam is psychiatrist and is the first one who holds a special chair in 'Philosophy of Life and Mental Health, with particular attention to the Psychiatry'. The Chair at the University for Humanistic Studies at Utrecht (NL) is set by the KSGV, Knowledge Centre for Philosophy of Life and Mental Health.

## New Releases

### New journal: Spirituality in Clinical Practice

American Psychological Association will soon release a new journal: "Spirituality in Clinical Practice". According to journal's webpage ([www.apa.org/pubs/journals/scp](http://www.apa.org/pubs/journals/scp)), it "is a practice-oriented journal that encompasses spiritually-oriented psychotherapy and spirituality-sensitive cultural approaches to treatment and wellness. SCP is dedicated to integrating psychospiritual and other spiritually-oriented interventions involved in psychotherapy, consultation, coaching, health, and wellness."

Lisa Miller (Columbia University) and Len Sperry (Florida Atlantic University) are the editors. Lisa Miller is the editor of the 2012 "Oxford Handbook of Psychology and Spirituality".

## Calendar of events

### April 2014

11-12 [I International Symposium of Spirituality in Clinical Practice](#). Porto Alegre, Brazil. Promoted by Psychiatric Association of Rio Grande do Sul. A two-day symposium with speakers from Brazil and USA: Robert Cloninger, James Lomax, Lionel Corbett, Paulo Dagalarrondo,

Alexander Moreira-Almeida, and Giancarlo Lucchetti.



### September 2014

14-18 [16th World Congress of Psychiatry](#). Madrid, Spain. Six symposia on Religion, Spirituality and Psychiatry have already been approved: “Religious perspectives on mental health”, “Consensus and Position Statements on Psychiatry, Religion and Spirituality”, “Implications of spiritual experiences to mind-brain relationship and clinical practice”, “Spiritual and religious concepts of Mental Order and Disorders”, “Spiritual component in clinical exercise”, and “Conexiones: espiritualidad-religiosidad-psiquiatria”. These symposia involve authors from nine countries and four continents. More details [here](#).



### October 2014

15-18 [XXXII Brazilian Congress of Psychiatry](#). Brasilia, Brazil. A keynote speech by Prof. Dan Blazer (USA) on “The Empirical Study of Religion/Spirituality and Psychiatric Disorders” and an international course on “Religiosity and clinical practice: What and how to do?” have already been approved.



You are all invited to send your opinions about unmet needs in psychiatric teaching, training, and care concerning religion and spirituality, difficulties faced during practices, stories from different cultures and future research plans to improve our understanding of the links between psychiatry and spirituality as well as mental health care.

I am sure you will assist us in this coming effort by sending your contributions and comments.

Prof. Nahla Nagy

Secretary Section Religion, Spirituality & Psychiatry  
[nahlanagy64@yahoo.com](mailto:nahlanagy64@yahoo.com)

### Join the Section

#### Join the WPA Section on Religion, Spirituality and Psychiatry!

If you are a clinician or researcher working with mental health and have an interest in spirituality, you can become a member of our section. It is free and would allow you to be in touch with peers that share your interests. Some benefits:

- You will be kept posted on the latest developments in Spirituality and Psychiatry around the globe!
- Possibility of contributing to the discussion and improvement of the understanding, scientific research, and clinical integration of spirituality in mental health care
- Networking with researchers and clinicians from all over the world

To join us it is free and easy, you just need to fill the form [here](#).

[www.wpanet.org/joinSection.php?section\\_id=11](http://www.wpanet.org/joinSection.php?section_id=11)

### Meeting point

Dear Colleagues,

In the section of Religion, Spirituality & Psychiatry, we have great interest in communicating with our colleagues besides our website.