



Stichting Psychiatrie en Religie  
**DUTCH FOUNDATION FOR PSYCHIATRY AND  
RELIGION**

**2ND INTERNATIONAL CONFERENCE:**

**RELIGIOUS PSYCHOPATHOLOGY:**  
Explorations at the interface of  
psychiatry and religion

17-19 March 2008

Congress Venue Leiden, Het Poortgebouw  
The Netherlands

In collaboration with the Spirituality and Psychiatry  
Special Interest Group of the Royal College of  
Psychiatrists (UK) and under the auspices of the  
World Psychiatric Association



**WORLD PSYCHIATRIC ASSOCIATION**



## **PROGRAM**

**2ND INTERNATIONAL CONFERENCE:**

# **RELIGIOUS PSYCHOPATHOLOGY:** Explorations at the interface of psychiatry and religion

17-19 March 2008



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## WELCOME

Dear colleagues,

It is a privilege to welcome you, on behalf of The Dutch Foundation for Psychiatry and Religion, at our second international conference, which will be held in Leiden (Netherlands), 17-19 March 2008. This conference is organized in collaboration with the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists in London (UK) and the World Psychiatric Association Section on Religion, Spirituality and Psychiatry.

### Theme

The theme of this scientific conference will be Religious Psychopathology: Explorations at the Interface of Psychiatry and Religion.

The conference will address

Conceptual issues: borderline between religion and psychopathology; religious psycho-pathology as a challenge to the concept of disease

Depression and suicide: boundary questions, phenomenology, epidemiology, and suicide risk

Psychosis: phenomenology, epidemiology, mystic experiences, and religion as elicitor of psychosis

Faith, healing, and coercion

Religion and psychotherapy: countertransference issues; spiritually oriented psychotherapy; religious socialization; psychotherapy and pastoral care.

In clinical practice religious and spiritual issues are inextricably woven into patients' lives and do influence their disorders and the way they cope with their mental condition. Existential aspects affect the way symptoms are experienced and expressed. Underneath or behind the layer of symptoms and complaints there are often relational problems and/or psychodynamic conflicts; these, in their turn, not infrequently are derivative of religious and or spiritual problems. Too narrow conceptions of psychopathology wrongly exclude this spiritual / existential layer.

These issues are also important from a broader perspective. Religion did not disappear in western culture. The secularization thesis is replaced by the transformation thesis, new forms of religiousness and spirituality flourish more and more. No doubt the secularization thesis had a huge impact on how religion was viewed in western psychiatry. But the picture appeared to be richer and more complex. How does this remarkable cultural change affect our scientific thinking and the clinical practices that are based on this thinking? To what degree do new religious and spiritual manifestations affect epidemiologic data and in what way do these

transformations affect the phenomenology and course of psychiatric disorders? And how do these cultural changes affect the internal working models of mental health professionals, especially of psychiatrists? These are some of the questions that will be addressed at our meeting.

On behalf of the Executive Committee,  
Peter J. Verhagen, secretary

## **ORGANISATION**

The Dutch foundation for Psychiatry and Religion

## **EXECUTIVE COMMITTEE**

Prof. dr. G. Glas, MD PhD, chair  
Dr. H.J.G.M. van Megen, MD, PhD, treasurer  
Prof. dr. H.M. van Praag, MD, PhD, co-chair  
P.J. Verhagen, MD, secretary

## **MEMBERS OF THE BOARD** of the Dutch Foundation for Psychiatry and Religion:

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Prof. dr. R.W. Munk, PhD

[www.religionandpsychiatry.com/congress2008](http://www.religionandpsychiatry.com/congress2008)

## DUTCH FOUNDATION FOR PSYCHIATRY AND RELIGION

The Dutch Foundation for Psychiatry and Religion was founded in October 2000. The main purpose of the Dutch Foundation is to improve the relationship between psychiatry and spiritual care giving. In addition, the Foundation encourages research on the interface between psychiatry, religion and spirituality. It also stimulates the dissemination of knowledge and scientific data on religious and spiritual issues, in relation to psychiatry and allied domains. The Foundation organizes national and international conferences, workshops, professional training and public lectures.

The Dutch Foundation for Psychiatry and Religion collaborates with other national and international organizations:

KSGV, a Dutch Association, that endeavours to inspire the investigation of and reflection on current religious issues in mental healthcare and in society; see: [www.ksgv.nl](http://www.ksgv.nl);

SIG, the Special Interest Group on Spirituality and Psychiatry of the Royal College of Psychiatrists (London, UK); see:

<http://www.rcpsych.ac.uk/college/specialinterestgroups.aspx>.

WPA Section on Religion, Spirituality and Psychiatry; see: [www.religionandpsychiatry.com](http://www.religionandpsychiatry.com).

The Dutch Foundation for Psychiatry and Religion organized its first international symposium in 2002, Amsterdam. Recently, the material of this conference was published in a scholarly publication *Hearing Visions and Seeing Voices*, Glas et al. (eds.); Dordrecht: Springer; 2007. The book will be available at the conference. The executive committee of the second international conference is working on a proposal in order to publish the material which is going to be presented and discussed at this conference.

## SPONSORS

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## **PROGRAM**

### ***Monday evening, March 17, 2008***

- 19.00            Opening session  
                  Chair: Prof. dr. Gerrit Glas
- 19.15            Introduction to the conference theme  
                  Peering through the Cleft in the Rock:  
                  Countertransference and the Representation of God  
                  in the Context of Psychoanalytic Work  
                  *Moshe H. Spero (Professor of Social Work and  
                  Psychoanalysis, Bar-Ilan University, Ramat-Gan,  
                  Israel)*
- 20.15            Cults: Faith, healing, and coercion  
                  *Marc Galanter (Professor of Psychiatry, New York  
                  University, United States of America)*
- 21.15            WELCOME RECEPTION, invitation for all  
                  participants

## **Tuesday, March 18, 2008**

- Conceptual Issues  
Chair: Prof. dr. Reinier W. Munk
- 09.00 On the border between normal and abnormal religiosity  
*Herman M. van Praag (Emeritus Professor of Psychiatry, Apeldoorn, Maastricht, The Netherlands)*
- 10.00 Religious psychopathology as a challenge to the concept of disease  
*Gerrit Glas (Professor of Philosophy and Psychiatrist, Zwolle/Leiden, The Netherlands)*
- 11.00 COFFEE BREAK
- 11.30 Coming to terms with losses in schizophrenia: the search for meaning  
*Hanneke Muthert (Theologian and Spiritual Caregiver, Groningen/Assen, The Netherlands)*
- 12.30 LUNCH, Boerhaaveplein LUMC
- Psychosis  
Chair: Dr. Harold J.G.M. van Megen
- 13.30 Defining and measuring spirituality.  
*Michael King (Professor of Psychiatry, London, United Kingdom)*
- 14.30 Mystical experience and psychosis. A historical and systematic reflection on an often assumed affinity.  
*Patrick Vandermeersch (Professor of Psychology of Religion, Groningen, The Netherlands)*
- 15.30 TEA BREAK
- 16.00 Religious psychopathology: incidence phenomenology and epidemiology.  
*Andrew C.P. Sims (Emeritus Professor of Psychiatry, Leeds, United Kingdom)*
- 17:15 Social program, Congress dinner, upon reservation

## **Wednesday, March 19, 2008**

- Depression and suicide  
Chair: Peter J. Verhagen
- 09.00      Religiosity, spirituality, depression: the issue of the boundaries  
*John Peteet (Associate Professor of Psychiatry, Harvard Medical School, Boston, United States of America)*
- 10.00      Religiosity and suicide risk  
*A. Apter (Professor of Psychiatry, Tel Aviv, Israel)*
- 11.00      COFFEE BREAK
- 11.30      God image in older adults in The Netherlands: recent research findings.  
*Arjan Braam (Psychiatrist, Utrecht, The Netherlands)*
- 12.30      LUNCH, Boerhaaveplein LUMC
- Religion and psychotherapy  
Chair: Prof. dr. Herman M. van Praag
- 13.30      The Need for Psychiatry of the Whole Person: "Spirituality and Mental Health".  
*Ahmad Mohit (Psychiatrist, Poet, WHO, Teheran, Iran)*
- 14.30      Soul and Self, Pastor and Psychiatrist: a multilevel, interdisciplinary and relational paradigm.  
*Peter J. Verhagen (Psychiatrist and Theologian, Harderwijk, The Netherlands)*
- 15.30      TEA BREAK
- 16.00      Religious socialization as a variable in psychotherapeutic treatment  
*Harold J.G.M. van Megen (Psychiatrist, Ermelo, The Netherlands)*
- 17.00      Closure  
Gerrit Glas

# KEYNOTE SPEAKERS AND ABSTRACTS

## **ALAN APTER**

Alan Apter is director, Child and Adolescent Division, Schneider Children's Medical Center of Israel, 1999 - present; Chairman, Dept of Psychiatry, Sackler School of Medicine, University of Tel Aviv, 1996-1996; Director, Child and Adolescent Division, Geha Psychiatric Hospital, 1995-1999; Visiting Professor, Yale School of Medicine, Child Study Center, 1994-1996; Director, Child and Adolescent Division, Geha Psychiatric Hospital, 1992-1993; Director, Adolescent Unit, Geha Psychiatric Hospital, 1990-1998; Chairman, Child and Adolescent Psychiatry, Sackler School of Medicine, Tel-Aviv University, 1990-1990.

Research interests:

- Adolescent suicide
- Adolescent psychiatry

### **Religious factors affecting suicide**

Objectives:

To: discuss

1. Empirical the influence of religion on suicide
2. The relationship of one particular religion-Judaism with suicide

Methods:

1. A systematic search of empirical studies on the effect of religion on suicide was performed.
2. The Jewish approach to suicide through biblical, Talmudic and modern times was surveyed

Results:

Most case control / cohort studies indicate that religious engagement protects against suicide (Hilton 2002; Duberstein 2004). Ecologic studies (Neeleman, 1997, 1998, 1999) suggest in Western countries high levels of belief are associated with lower rates of suicide and that this is more marked in females than in males.

These lower rates appear to be mediated by a reduced acceptability of suicide and are independent of ethnic, genetic, social and cultural.

There is however some inconsistency in evidence: e.g. Marusic, 1998.

The Jewish approach to suicide has undergone marked vicissitudes over 3,000 years of evolution. After being accepted and tolerated in biblical times it became sinful and excommunicable in Talmudic times. During the holocaust the act of suicide became a focal point of controversy in the face of an intolerable external situation.

Conclusions . There is both empirical and historical evidence for a major effect of religion on suicide.

## **ARJAN BRAAM, MD, PhD**

Arjan W. Braam (1969) is consultant psychiatrist in Altrecht Mental Health Care, Department of Emergency Psychiatry, Utrecht, the Netherlands, and senior researcher in the Institute of Extramural Medicine (EMGO-Institute) at the VU University Medical Center, Amsterdam, the Netherlands. Since 1992, he is a researcher in the Longitudinal Aging Study Amsterdam (LASA), a gerontological and epidemiological prospective research initiative. His work consists of empirical studies in the field of religion and mental health, and depression in later life in particular, with an emphasis of identifying both adaptive and maladaptive aspects of religiousness in a secularising society.

### **God image in older adults in The Netherlands: recent research findings**

Affective or emotional aspects of religiousness are considered to be crucial in the association between religiousness and well-being, especially in later life. The emotional aspects of religiousness, can be understood as pertaining to the God image, or better defined as the God-object-relationship, corresponding to feelings of trust towards God or to religious discontent. In the current contribution, empirical findings are discussed about associations between God image, depressive symptoms, feelings of guilt, and personality characteristics, such as defined by the Five Factor Model of Personality.

As part of a pilot study of the Longitudinal Aging Study Amsterdam, a small sample of older church-members ( $n = 60$ ), aged 68-93, filled out a questionnaire, including the Questionnaire God Image on feelings to God and perceptions of God, and items on hopelessness, depressive symptoms, and feelings of guilt, and the 120-item version of the NEO-PI-R.

Feelings of discontent towards God correlated positively with hopelessness, depressive symptoms, feelings of guilt, and also with depressive symptoms assessed 13 years earlier; these findings pertained to Protestant participants in particular. Most facets of God image, positive, critical, and about punishment reappraisals, were associated with more feelings of guilt. A possible explanation for the most pervasive finding, that feelings of discontent towards God are related to depressive symptoms, is that both, throughout life, remain rooted in insecure attachment styles.

Neuroticism was associated to feelings of anxiety towards God as well as discontent towards God. Agreeableness was associated to perceiving God as supportive and to prayer. These findings persisted after adjustment for depressive symptoms. For the other three

personality factors (Extraversion, Openness, and Conscientiousness), no clear patterns emerged. As in studies about God image and Five Factor Model of personality among younger people, some of the current results were prominent.

## **MARC GALANTER, MD, PhD**

Marc Galanter M.D. is Professor of Psychiatry at NYU, Founding Director of the Division of Alcoholism and Drug Abuse at NYU, and Director of the NYU Fellowship Training Program in Addiction Psychiatry. He is also a Division Director at NYU's World Health Organization Collaborating Center, and Director of its national Center for Medical Fellowships in Alcoholism and Drug Abuse. He is Editor of the journal "Substance Abuse," the annual book series "Recent Developments in Alcoholism," and author of the books, "Network Therapy for Alcohol and Drug Abuse" and "Spirituality and the Healthy Mind: Science, Therapy and the Need for Personal Meaning." His NIH and foundation-funded studies have addressed family therapy for substance abuse, pharmacologic treatment for addiction, self-help treatment for substance abusers, and spiritually-oriented recovery. Dr. Galanter attended Albert Einstein College of Medicine where he did his residency in psychiatry. After that he was a Clinical Associate at the National Institute of Mental Health, and then an NIH Career Teacher. He later served as President of the Association for Medical Education and Research in Substance Abuse (AMERSA) (1976-1977), the American Academy of Addiction Psychiatry (1991-1992), and the American Society of Addiction Medicine (1999-2001). Among his awards are the Gold Achievement Award for innovation in clinical care and the Seymour Vestermark Award for Psychiatric Education, both from the American Psychiatric Association, the McGovern Award for medical teaching from AMERSA, and New York State's Award for Psychiatric Research. See [www.med.nyu.edu/spirituality](http://www.med.nyu.edu/spirituality).

### **Cults: Faith, healing, and coercion**

This lecture will present illustrations of cultic behavior with a discussion of the underlying social psychology of cult members, followed by a description of a systems model that clarifies how such groups exert their influence on individuals. It will close with an illustration of cultic behavior as evident in positively oriented healing groups. In recent decades, we have witnessed the emergence of a number of cultic groups that have led to the death of innocent people, among them the People's Temple in Jonestown, the Aum Shinrikyu in Japan, and Heaven's Gate in California. A model for the psychology of such groups can be formulated on the basis of empirical studies carried out on the Divine Light Mission, a group of Indian origin, and the Unification Church, derived from Korea (Galanter). These studies were carried out on large samples of members employing quantitatively-grounded, validated, self-report scales.

Findings in an initial study on the Divine Light Mission revealed a significant negative correlation between members' psychological distress and the degree of affiliation they felt toward the group. Subsequent studies on the Unification Church showed that members' well-being was also significantly correlated with the degree of their acceptance of the group's religious creed. Furthermore, among potential inductees, it was only those who scored lowest on psychological well-being who stayed in the induction sequence, and ultimately joined.

On the basis of these and other studies, it is possible to formulate a model of cult affiliation whereby respective members' compliance with group norms is operantly reinforced by the relationship between their affective status and the intensity of their affiliation toward the group. This psychological model is compatible with a sociobiological approach, wherein close ties between individuals are fostered by the adaptive advantage lent related members of a species by traits such as reciprocal altruism (Trivers). In larger groups, a systems model (von Bertalanffy) based on the same sociobiologically-derived behaviors may apply among unrelated individuals. Social forces then emerge wherein the group itself is validated by engagement of new members, and is protected from dissolution by functions of internal monitoring and boundary control.

Such intensely affiliative groups may appear in modified form in spiritually-oriented healing movements, wherein presumptively health-promoting behavior is supported by group affiliation and adherence to a healing ideology that is typically associated with a progenitor charismatic leader. Illustrations of this latter phenomenon will be presented in relation to Twelve-Step programs for addiction such as Alcoholics Anonymous, and a mental health oriented program, Recovery Inc.

## **GERRIT GLAS, MD, PhD**

Gerrit Glas is psychiatrist and philosopher. He has two chairs: 'Philosophical Aspects of Psychiatry' (Leiden University Medical Centre) and 'Christian Philosophy from a Reformed Perspective' (Faculty of Philosophy, Leiden University) in Leiden, The Netherlands. He is also director of residency training in Zwolse Poort (Zwolle, NL). His main topics of interest are anxiety and anxiety disorders; philosophy of neuroscience; philosophical aspects of human nature in the light of the life sciences; the concept of personal identity; epistemological aspects of diagnosis, classification and the concept of disorder; and psychiatry and religion. He wrote around 120 scholarly papers, articles and chapters. Many of them can be found at the digital repository of Leiden University ([www.openaccess.leidenuniv.nl](http://www.openaccess.leidenuniv.nl)). He is also author and/or editor of 7 books. He is editor of G. Glas, M.H. Spero, P.J. Verhagen & H.M. van Praag, *Hearing Visions and Seeing Voices. Psychological Aspects of Biblical Concepts and Personalities* (Dordrecht: Springer/Kluwer Academic Press, 2007). He is editor in chief of *Psyche en Geloof* (Psyche and Faith), a Dutch scientific journal in the area of religion, psychiatry, and psychology. He is also editor of a (Dutch) book series on Psychiatry and Philosophy at Boom (Amsterdam).

### **Religious psychopathology as a challenge to the concept of disease**

The main thrust of this paper is that religious psychopathology offers one of the best illustrations of the idea that the nature of disease and the boundaries of the profession cannot be settled on purely objective grounds only. It is in the nature of religious psychopathology to compel clinicians and theorists to become explicit about all kind of background ideas and assumptions – assumptions about what it is to be ill or to have a disease, the concept of (dis)function and the nature of religion. In fact, religious psychopathology challenges us to go one step further by overcoming the split between strictly objective and subjective accounts of disease; and the split between fact and value. In a discussion of several case examples we will explore these background assumptions systematically with reference to the existing literature and discussions on the concept of disease in psychiatry.

## **MICHAEL KING, MD, PhD, FRCP, FRCGP, FRCPsych**

Michael King completed his medical studies in New Zealand before coming to the United Kingdom to undertake a vocational training in general practice at the Hammersmith Hospital. He then moved to the Maudsley Hospital to train in psychiatry and later trained in psychiatric epidemiology at the General Practice Research Unit under the leadership of the late Professor Michael Shepherd. Thus, much of his research focuses on primary mental health care. He is interested in how GPs recognise and manage mental health problems and the epidemiology of such problems in primary care populations. He has particular expertise in the methodology of randomised trials of complex interventions in primary and secondary care. He also has research and clinical interests in cognitive behaviour therapy and in sexual medicine.

### **Defining and measuring spirituality**

The need to take account of spirituality in research and health services provision is assuming ever greater importance. However the field has long been hampered by a lack of conceptual clarity about the nature of spirituality itself. In this presentation I shall challenge the sceptical claim that it is impossible to conceptualise spirituality within a scientific paradigm. I shall provide a brief over-view of critical thinking and propose a definition of spirituality for research and clinical work. Unfortunately, lack of specificity in defining spirituality has led to the development of instruments that appear to be measuring a range of issues from a search for meaning to sense of connectedness to others. They are also confounded with items measuring the consequences of spiritual and religious belief such as positive character traits or better health or greater happiness. This poses a challenge to outcome research. Including items on the consequences of spirituality in the instruments themselves renders tautological research into the outcomes of spirituality. The most useful instruments that have been developed to measure spirituality will be reviewed and critiqued.

## **HAROLD J.G.M. VAN MEGEN, MD, PhD**

Harold van Megen is psychiatrist and director of residency training in Meerkanten GGZ (Ermelo, NL). His main topics of interest are anxiety and anxiety disorders, especially the obsessive-compulsive disorder. He is author and (co)editor of scholarly papers, articles and book chapters.

### **Religious socialization as a variable in psychotherapeutic treatment: The Dutch situation**

Since the 70-ties, Christianity almost doubled its followers around the world. In 2005, the number of Christians was estimated around the 2,61 billion disciples. In steep contrast to that, in western Europe and in particular, the Netherlands, the number of people regarding themselves as believing in God seriously declined. In 1950 still 80% of the Dutch considered themselves belonging to one of the Christian denominations, whereas in 2006 this number shrank to only 24%. Nowadays, the majority of the Dutch considers themselves as 'enlightened' and secularized and consider religious people as dull and intellectual inferior, and if this is too bold, yet, at least as old fashioned. The average Dutch holds the opinion that religion might possibly have influenced the lives of their parents or grand parents but not their own. They are freed from it, their thinking autonomous. If this is true, there is no need for a psychiatrist/psychotherapist to pay any attention to someone's religious roots. But are they right? Every days life shows a different picture. The Dutch possesses a number of obvious (Calvinistic) habits, which they are so used to that they are no longer aware they have them. For example, the averaged Dutch hates hierarchic relations but is so convinced of its own right that others (friends, neighbors, colleagues and in general all people) better follow their ideas ('read instructions'). In politics, instead to strive for consensus, they tend to split up, founding their own political movement. Christian looking after the deprived is passé but we are enchanted to gather huge amounts of money for victims of natural disasters. In contrast to the hedonistic Belgians, the Dutch need to scale down everything that even smells at enjoyment by adding "tje" to the word, meaning small/less (e.g. diner-tje, beer-tje, kiss-tje). People who are successful in business or in academics are especially valued when they presume not on their achievements and stay as ordinary and as invisible as possible. (Former) Protestants, (former) Roman Catholics are religiously socialized and have specific premises of which they are often no longer aware of, but which do play a major role in the way they perceive life and the way they need to act. This

presentation will elaborate on these underlying mechanisms especially in relation to the psychotherapeutic process.

## **AHMAD MOHIT, MD, PhD**

Ahmad Mohit (1943) did his primary and secondary school education and moved to Tehran where he finished high school education and later entered into the Tehran Medical University as a medical student. He earned his MD degree in 1968. He later moved to the United States to pursue his residency in the field of psychiatry in Temple University in Philadelphia, PA. After passing the US Psychiatric Board exam in 1978, he returned to Iran and established the Tehran Institute of Psychiatry where he worked until 1992 as the Chairman of Psychiatric group of Iran Medical University. Among his major achievements in this period are organization of numerous educational seminars and workshops in psychology and psychiatric studies and also the establishment of Iran mental health network which gained world wide attention in the past decade. In 1992, Dr. Mohit was invited by World Health Organization to work as the East Mediterranean Regional Advisor of Mental Health in Alexandria, Egypt. After 10 years of working in this position, he recently was promoted as the Director Health Protection and Promotion.

### **The Need for Psychiatry of the Whole Person. "Spirituality and Mental Health"**

Many meanings can be attached to the word "spirituality". These range from belonging or inner devotion to a religion or an ecclesiastic, to having a predominantly spiritual character as shown in thoughts and life. Here this word is selected to refer to any experience or way of life, religious or otherwise, which can help the person to detach from the trivia, transcend and reach a calming and reassuring level of connectedness, meaning and purpose. Understanding the spiritual experiences may vary with cultures, individuals, and different stages of life. Such understanding may also be affected by the prevailing modes of conceptualizing health and disease in general and mental health and illness in particular. The clear example is understanding of mental illnesses based on a purely "biomedical" model in which living organism is basically seen as a biological machine and diseases are viewed as very specific entities as compared to a mainly "integrative, holistic" model, which takes all aspects of life including spirituality and culture into consideration.

The spiritual experiences may be connected to schools of thought and ways of life presented in mysticism. The word mysticism as it is understood in the west is the equivalent of two Arabic words. The first one is "Sufism" which refers to the Beliefs and rituals of Sufi groups for becoming united with God and the universe. It also can be the equal of

the word “Irfan”, used commonly in Iran, which its literary meaning is “Knowing.” In this sense it refers to the inner, intuitive knowledge which helps becoming united in existence with God, the rest of humanity and the universe. This is why Mysticism should not be understood in the narrow sense of mystic cults and their rituals. In many cultures, mystic beliefs influence art, music, literature and humanities. Such influence in turn, affects the life of the ordinary people who are not regular practitioners of mystic rituals. In Christian beliefs it has direct connection with healing, blessed wellness and cursed or “blessed suffering”.

Studying the impact of Spirituality, Religion and Personal Beliefs (SPRB) was a part of the WHO Quality of Life (WHO-QOL) programme for mental health promotion during the decade of Nineties. In 2001 a SPRB module for conducting studies in this area was developed in which, eight facets of Spiritual Connection, Meaning and Purpose of Life, Experience of Awe and Wonder, Wholeness and Integration, Spiritual Strength, Inner Peace, Hope and Optimism and Faith were identified.

## **HANNEKE MUTHERT, PhD**

Hanneke Muthert (1973), theologian, is a teacher at the Faculty of Theology and Religious Studies of the University of Groningen in the Netherlands (the Master Spiritual Care), and spiritual caregiver at the Drenthe Mental Health Trust in the Netherlands. Her recent work focuses on grief and mourning processes in schizophrenia and how these processes relate to the construction of (religious) meaning making. Other topics of recent interest are life and work of W.R. Bion; the education of mental health practitioners on existential themes in psychiatry related to their own philosophies of life; the role of spiritual caregivers in psychiatry.

### **Coming to terms with losses in schizophrenia: the search for meaning**

Schizophrenia is widely recognised as a seriously disabling illness. Different kinds of losses are mentioned, for example the loss of health, the loss of dreams, longings and expectations about one's future, the loss of skills, work, relationships and losses associated with being stigmatized. The psychological and existential suffering of people diagnosed with schizophrenia or related psychosis is experienced by patients, their relatives and friends and by many workers in psychiatry as well. However, in the clinical context there is lack of instruments and interventions that focus specifically on the existential suffering. By working on this subject at the Drenthe Mental Health Trust we discovered the importance of the search for meaning experienced by service users.

This paper elaborates on three topics:

The presentation of a constructivistic model to look at the specific losses mentioned before, which focuses on the search for (religious) meaning. This model is linked to theories of rehabilitation and recovery.

The evaluation (based on semi-structured interviews) of a training course which was developed to support caregivers in their reactions to patients who experience losses. We anticipated an improvement of the supporting skills trained in the course. The second hypothesis concerned the participant's philosophies of life. We expected a decrease in reactions dominated by the care givers philosophy of life. We also assumed that participant's sense of powerlessness when confronted with the existential losses presented by service users would decrease.

In short, an exploration of the role of the spiritual caregiver.

Special attention is given to religious meaning making.

## **JOHN PETEET, MD, PhD**

After receiving his MD degree at Columbia and a medical internship at UNC in Chapel Hill, he trained in psychiatry at the Massachusetts Mental Health Center, and completed a fellowship at the Peter Bent Brigham Hospital, in Boston. For over 25 years he has served as a psychiatrist at Brigham and Women's Hospital and Dana-Farber Cancer Institute, where he is an Associate Professor of Psychiatry at Harvard Medical School. Board certified in psychiatry and psychosomatic medicine, he has received awards for teaching and has published numerous papers in the areas of psychosocial oncology, addiction, and the clinical interface between spirituality/religion and psychiatry. In 2004 the American Psychiatric Association Press published his book *Doing the Right Thing: An Approach to Moral Issues in Mental Health Treatment*, and another that he co-edited, the *Handbook of Spirituality and World View in Clinical Practice*. He is writing a book on the spiritual dimension of depression, and currently chairs the American Psychiatric Association's Corresponding Committee on Religion, Spirituality and Psychiatry.

### **Religiosity, Spirituality, and Depression: The Issue of the Boundaries**

What distinguishes depression from a spiritual problem? In what ways can depression present a spiritual problem? When both are present, how can one assess the relationship between them?

As the psychiatric classification of depressed states continues to evolve, interest grows in distinguishing conditions based on the type of vulnerability they confer. For example, a lowered mood can reflect melancholic, bipolar or psychotic illness; depression associated with personality, addiction and trauma; adjustment disorder; complicated grief; demoralization; angst; guilt; the "dark night of the soul"; or ordinary unhappiness. Each of these may be associated with characteristic existential challenges, spiritual concerns, and, at times, religious distress. Differentiating religious from psychopathological phenomena seems less helpful clinically than clarifying what spiritual interventions are needed to address a depressed patient's existential concerns. This entails a focus on the boundaries of the clinician's role in providing spiritual care.

## **HERMAN M. VAN PRAAG**

Prof. Van Praag established the first department of biological Psychiatry in Europe (Groningen, the Netherlands) and became the first European Professor of Biological Psychiatry in 1968. Subsequently he became head and professor of psychiatry at the University of Groningen, Utrecht, the Albert Einstein College of Medicine, New York (USA) and the University of Maastricht. He is the author or editor of numerous books. He is the author or co-author of numerous articles and book chapters. He also wrote on the topic of religion and psychiatry (e.g. Psychiatry and Religion. An unconsummated marriage, 2007).

### **About the borders between normal and abnormal religiosity**

Starting point of this lecture is the standpoint that religiosity (or: religious receptivity) is a normal component of the human experiential repertoire, emphatically not a neurotic remnant of an infantile past. The underpinnings of this viewpoint will be discussed, as well as the meaning of the term religious receptivity.

Assuming the normality of religiosity, one may expect the occurrence of abnormal manifestations both in the direction of an excess (pietism) and in the direction of a deficit (unbelief).

Abnormal manifestations of religiosity will be discussed.

The practical consequence of this view is that religiosity should regain its rightful place in psychiatric diagnosing and therapeutic planning and consequently in psychiatric training programs.

## **ANDREW C.P. SIMS, MA, MD, FRCPsych, FRCP**

Andrew Sims is emeritus professor of psychiatry, University of Leeds, UK. He is a former president of the Royal College of Psychiatrists (UK). He is the well known author of 'Symptoms in the Mind. An Introduction to Descriptive Psychopathology' (3th edition 2003 Saunders).

### **Religious psychopathology: incidence, phenomenology & epidemiology**

Since the increase of awareness in spirituality and religion amongst psychiatrists in the last two decades, 'religious psychopathology' has also become of consummate interest and generated much exploration, but what is it? This paper will seek to answer that question by considering what psychopathology is, and then concentrating upon descriptive psychopathology. Descriptive psychopathology that has religious content will be investigated.

Using this method to examine unusual religious speech and behaviour, it will become apparent that such behaviour may arise in the context of an individual with other manifestations of mental illness, and sometimes not. In the past, some psychiatrists regarded all religious affiliation and activity as evidence of mental illness or abnormality of personality. The possibility of religion being causative and prolonging mental illness will be explored. An attempt will be made to find guidelines to distinguish between unusual belief and mental illness; of course, the two frequently occur together.

Because these concepts are not clearly delineated, it is difficult to make quantitative assessments and to give definite figures. The incidence of 'religious psychopathology' has changed over time, and in different societies. Epidemiological factors will be investigated as far as possible from a limited database. A study of phenomenology and epidemiology in such people will assist in plans for effective psychiatric management.

## **MOSHE H. SPERO, PhD**

Moshe Halevi Spero is full Professor and Director of the Postgraduate Program of Psychoanalytic Psychotherapy, Weisfeld School of Social Work, Bar-Ilan University; Senior Clinical Psychologist, Department of Psychiatry, Sarah Herzog Memorial Hospital; Senior Clinical Psychologist, Weinstock Oncology Day Hospital, Shaare Zedek Medical Center, Jerusalem; Scientific Associate, The American Academy of Psychoanalysis and Dynamic Psychiatry; Author of *Religious Objects as Psychological Structures* (University of Chicago Press, 1992) and co-editor of *G. Glas, M.H. Spero, P.J. Verhagen & H.M. van Praag, Hearing Visions and Seeing Voices: Psychological Aspects of Biblical Concepts and Personalities* (Dordrecht: Springer/Kluwer Academic Press, 2007).

### **Peering through the Cleft in the Rock: Countertransference and the Representation of God in the Context of Psychoanalysis**

Previous reviews of the psychoanalytic literature dealing with the topic of religion and faith amply demonstrate how far we have advanced from the earliest models of religious belief in (or images of) God as a neurosis, an illusion or even a "normative" and salutary illusion (Winnicott, et al). This change is not confined to the realm of theory, and has encouraged clinical psychoanalysts to enable their patients to bring such beliefs and representations into the analytic hour, but this "enabling" has required that analysts learn to contend with a significant clinical paradox: Namely, psychoanalysts have needed to find a way to simultaneously guarantee the "safety" of religious object representations within the analytic framework even as they enable these objects and feelings to participate in the analytic transformatory processes which, as we now, involves considered risk of destabilization, regression and sometimes radical modification in religious belief and experience. Along with the previously mentioned change, many psychoanalysts have acknowledged forthrightly that our commitment to the interactivity of the transference-countertransference matrix--a commitment which crosses almost all analytic schools--requires that the analyst allow his or her own religious beliefs and images, or apparent lack thereof, to also be accessible during the analytic hour (and that there are risks involved with this accessibility as well). These new, creative refractions of the countertransference experience --predicated upon the analyst's awareness of and comfort with the roots of his or her own religious commitments and representations--should teach us new things about the genesis of divine object representations (or, the experience-near concept

of "God"), especially about the early, preoedipal and even presemantic foundations of religious experience.

The preceding acknowledgement has sharpened our awareness that it is not the psychotherapist's professed or conscious beliefs about religiosity or about the existence of God that are relevant to the kind of transformations that may take place within the patient. Rather, our clinical concern focuses upon the level of accessibility the therapist has to the unconscious vicissitudes of his or her own representational activity regarding the kinds of psychic experiences that have to do with that which we refer to as "God" (or by whatever name). In this paper, drawing on my own clinical work and the work of others, I wish to delineate some theoretical ideas that have crystallized for me. I shall distinguish between 3 dimensions of God representation: the pathological lack of any representation of God, the conflict-bound absence of a representation of God, and the maturely internalized representation of God.

The first dimension is a null dimension -- in this case, there seems to be no psychological evidence of any representation of God in any form. While some theoreticians have argued that there is no human, brought up in the cultures that we know of, who lacks a God representation of some kind, I believe that (if we mean by God representation something more than a mere mental image or capacity for work-recognition), it is possible to imagine circumstances in which there is a gap or lacuna where one might ordinarily expect to find a God representation. The third dimension might be viewed as the "healthy" dimension wherein God is experienced as most present, and the relationship with God as most profound, precisely because of a sense of absence; that is, owing to the degree to which the concrete or personified presentational trappings associated with the experience of God have been internalized and symbolized. This last dimension is not envisioned as an absolute or constant state; it seems to flourish most within personalities who have the capacity to oscillate or shift between such states and states that are more representationally concrete and personified.

The middle dimension is similar to the last, though the quality and quantity of representational oscillation and identification is bound by intense conflict, restlessness, torment and potentially catastrophic crisis.

Obviously, these 3 dimensions can be seen directly, or their existence inferred, in nonclinical settings, including experimental inquiry.

However, like all laboratory conditions, the analytic framework and the transference-countertransference matrix enable us to peer more deeply into the latent or occult dynamics -- the bright lights and the blind spots -- of the representational "coming into being" of God.

## **PATRICK VANDERMEERSCH**

Patrick Vandermeersch (1946) is full Professor of Psychology of Religion at the Faculty of Theology and Religious Studies of the University of Groningen (The Netherlands). Among his research interest is the complex nature of religious experience, whereby he attempts to disentangle the noetic content of belief and the distinct emotional layers in faith. Recently he has published *La chair de la Passion. Une histoire de foi: la flagellation*, (Passages) Paris, Cerf, 2002 and (together with H. Westerink), *Godsdienstpsychologie in cultuurhistorisch perspectief* [Psychology of Religion considered as an Element of the History of Culture], Amsterdam, Boom, 2007.

### **Mystical Experience and Psychosis. A historical and systematic reflection on an often assumed affinity**

Especially when they have an easily recognizable religious content, psychotic delusions seem to show us a 'generatio spontanea' of religion. Therefore the topic regularly appears in psychology of religion. Anton Boisen's *Autobiography*, Freud's *Schreber*, Jung's *Miss Miller* and Peter Schaffer's *Equus* are the best known examples of it. Nevertheless, two reasons should warn us against assimilating too easily both phenomena:

1. Despite of its striking character, delusion is only one of the elements of psychosis. When coining the term of 'schizophrenia', Eugen Bleuler made of it a secondary symptom, while disruption of affectivity seemed much more important to him. Following its emphasis on easily observable symptoms, the DSM III and IV put the emphasis on delusions again. This is however questionable and could turn us away from other, more essential points where psychosis could be compared with religious

experience: the emotional realm.

2. Thereby a religious bias could reinforce this limited focus on the content of delusions. Especially in the Anglo-Saxon world, due to the Calvinist tradition, religion is easily identified with belief, and believing with the acceptance without proof of some 'truths', i.e. specific propositions. One should however remember that in the history of Christian theology the emotional basis of the psychological act of 'believing' (trust - the *fides qua*) has often been considered more important than the content of the subsequent creed (*fides quae*). This too invites us to look differently at the seemingly likeness of psychotic and religious experiences.

3. Mystical experiences are a peculiar form of religious experience, that can also be shaped along ethical, esthetical, rational, sceptical, etc. lines. Thereby, in Christian tradition, mystical experience is often modelled according the pattern of intersubjectivity and love - something that is often precarious in psychosis. Here we meet the point where we have to investigate what psychotic people are especially looking for in religion, and this might be something very different from what we find, expressed on a cognitive level, in their delusions.

## **PETER J. VERHAGEN**

Peter Verhagen (1957) is psychiatrist, group psychotherapist, supervising therapist, and theologian. He is on the editorial board of *Psyche & Geloof* (Psyche and Faith), a Dutch scientific journal in the area of religion, psychiatry, and psychology, and of *Groepen* (Groups), the Dutch journal of group dynamics and group psychotherapy. He is secretary of the World Psychiatric Association (WPA) Section on Religion, Spirituality and Psychiatry.

### **Soul and Self, Pastor and Psychiatrist: a multilevel interdisciplinary and relational paradigm**

Pastor and psychiatrist both feel in the inner life of human beings like a fish in water. At the same time they use more or less, or even completely different discourses to describe, assess and interpret that inner life and its proclivities. What happened to the soul and the psyche? We are more or less accustomed to the fact that soul and psyche as concepts are representations of two separate discourses. And it is also clear that these two discourses keep up different relationships. Depending on 'Zeitgeist', cultural setting, scientific developments, and mindset of the professionals involved, clinicians and pastors or spiritual caregivers. Regarding mental health, it is usually said that the 'soul' has been neglected. That is to say, if we mean by soul religious and spiritual issues. The soul as such, as a concept is seldom used in mental health language. It is often said that the soul is substituted by the self. There is nevertheless differentiation of the terms soul and self possible.

On another level of abstraction it is possible to unfold the relationship between theology and psychology, parallel to the relationship between religion and science, according to the typology proposed by Barbour: conflict, watershed, dialogue and integration (Barbour, 2000). LeRon Shults explains that such an approach is a modernist one: the disciplines involved are separate positions, from which participants try to work out the relation between them (LeRon Shults, 2003). A postmodernist approach would take the relational unity of the two poles as prior, and would start from inside the relationality itself. The two disciplines are not separate poles but embedded in a broader relationality. Seen from this stance the interdisciplinary relationality helps to understand the disciplines, in stead of the other way around. In this contribution we will explore the meaning of this postmodernist intuition, not only on the level of the two disciplines (scientific level), but also with regard to the interdisciplinary dialogue among professionals (clinical level), pastors, spiritual caregivers and psychiatrist and psychotherapists.

## NOTES











