Towards a Transpersonal Psychiatry

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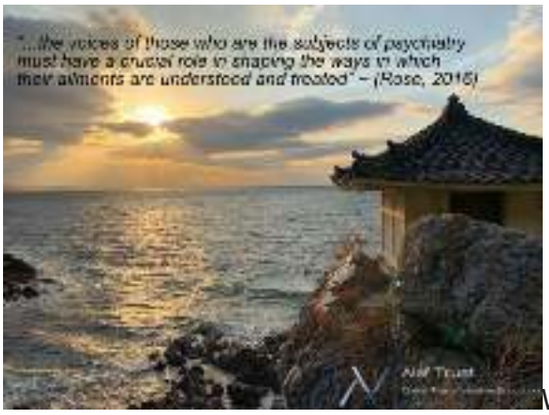
Modern psychiatry is in a state of crisis. 450 million people around the globe are affected by mental illness (1 in 10 adults). Looking at Europe and the U.S, over 40% of the total burden of disability is related to mental illness, and over 10 million Prozac prescriptions were issued in the first 5 years after its introduction into the pharmaceutical market (Powell, 2007). In 2013 and in England alone, over 53 million prescriptions were issued for antidepressants, a 6% increase on the previous year and a 92% increase since 2003 (Rose, 2016). The World Health Organization (WHO) estimates that each year approximately 800,000 people commit suicide, which represents a global mortality rate of one death every 40 seconds, and it is predicted that by 2020 the rate of death will increase to one every 20 seconds (WHO, 2014).

In order to respond to the growing collective distress, psychiatry will have to go through a global paradigm shift, where issues like meaning, faith, belief in GOD and altered states of consciousness, as well as advanced psycho-social models for crisis intervention will have to be common psychiatric knowledge. The following pages will begin with a short review of the origins of psychiatry and psychopathology and continue with a discussion on the role that transpersonal theory and practice can play in the transformation of the current paradigm in psychiatry.

The first hospitals for curing mental illness were established in India during the 3rd century BCE (Koenig, 2009), where the earliest known texts on mental disorders, the *Charaka Samhita*, were compiled between the 1st century BCE and the 2nd century CE (Scull, 2013). Already in the 4th century BCE, Hippocrates saw physiological abnormalities as a possible root of mental disorders (Elkes & Thorpe, 1967) and thus can be seen as the father of *biological psychiatry*. Today, although we know that neurobiological factors are playing a key role in modulating mood and behavior, we can also see that a psychopharmacological, electroconvulsive, or any other physical intervention are far from being enough to support a person who is going through a mental crisis.
The term “psychiatry” literally means the “medical treatment of the soul” (from ancient Greek *psykhē* “soul”; -iatry “medical treatment”) and it seems that many of the conflicts that arise these days in psychiatric practice can be traced back to the very notion that the soul could be medically treated.

Nikolas Rose (2016), a professor of sociology in King’s College London, explains that the extent of diagnosable ‘brain disorders’ (between 25% and 33%), the view of the brain as the ultimate locus for explanations of mental disorders and the use of psychiatric drugs as the primary mode of intervention,

all contribute to the current crisis in psychiatry (Rose, 2016). Rose also emphasizes that when the American Psychiatric Association (2013) published the 5th *Diagnostic and Statistical Manual of Mental Disorders*, there was not a single clinically validated biomarker for any psychiatric disorder, and that the genome wide association studies (GWAS) methodology have failed to provide any major insight into the genomic bases of psychiatric disorders (Rose, 2016). Some of Rose's (2016) conclusions are that we should go back to view mental disorders as a "disorder of a whole person" (p. 97) (and not just the brain), while taking notice of the patient's social and environmental setting; that we should remember that the patient is not "merely a sum of parts that can be isolated and experimented on in the purified space of the laboratory" and then extrapolated to the whole; that there is a clear correlation between diagnoses of mental disorder and "a whole range of undesirable social conditions" (p. 98); and that maybe the most revolutionary development will come from "the recognition that the voices of those who are the subjects of psychiatry must have a crucial role in shaping the ways in which their ailments are understood and treated" (p. 99).



While psychotherapeutic and social interventions can provide a great deal of support for psychiatric patients (whether if with or without medication), an issue that was not mentioned in Rose's provocative editorial is that the majority of psychiatric patients do not have someone to process the *spiritual nature of their experience* with. In a survey of 52 psychiatric inpatients in Minnesota, 95% of the patients declared a strong belief in God (Kroll & Sheehan, 1989). In another study, over 80% felt that their spiritual beliefs had a positive impact on their illness, yet over a third of them did not feel that they were able to discuss spiritual matters with their psychiatrists (Lindgren & Coursey, 1995). A study conducted by Bergin & Jensen (1990) showed that while in general population over 80% have a belief in God or a higher power, around only a third of psychiatrists and psychologists hold such beliefs. Thus, it is important to remember that when it comes to spiritual beliefs, it is not the psychiatrists that represent the norm (Powell, 2002). One reason for that gap might be the lack of spiritual knowledge and practice in current training programs for health professionals and the over-emphasis on the medical model. The following excerpt from a report of the WHO (World Health Organization) is emphasizing this point (WHO, 1998):

> The health professions have largely followed a medical model, which seeks to treat patients by focusing on medicines and surgery, and gives less importance to beliefs and to faith – in healing, in the physician and in the doctor-patient relationship. This reductionism or mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realise the value of elements such as faith, hope and compassion in the healing process (p. 7).

According to David Nichols, Professor Emeritus of Pharmacology in Purdue University and the founding president of the Heffter Research Institute, the current neurobiological paradigm in psychiatry emerged in 1954, when the discovery of the structural relationship between LSD and serotonin, lead to the realization that LSD's mental effects are caused by its interaction with the serotonergic system. This was the first formal recognition that perhaps brain chemistry had something to do with behavior, and particularly with mental illness (Nichols, 2013). In the words of Nichols: "To put things in context, up until that time, mainstream psychiatry had no idea that behavior might arise from neurochemical events in the brain" (2013, p. 22).

Between the 1950s and mid-1960s, LSD-assisted psychotherapy was an active research field, with more than 40,000 patients who contributed to the publication of 1,000 clinical papers on the subject

(Grinspoon & Bakalar, 1979). Research with this novel molecule came to an almost complete stop after it was declared as a *Schedule I* drug in the United States during the mid-1960s. Luckily, the rigorous psychedelic research that took place until that time was enough to draw the attention of many respected psychologists and psychiatrists to the importance of transcendent states and spiritual experiences for the psychotherapeutic process. One of these respected researchers was Stanislav Grof. After having himself a powerful transformative experience (Sala, 2008) using LSD as a research participant during his medical training, Grof decided to dedicate his life to the study of non-ordinary states of consciousness (NOSC). During the very same years that psychedelic drugs were made illegal in the United States, a group of researchers that included Abraham Maslow, Anthony Sutich, Miles Vich, Sonya Margulies and Stanislav Grof (Grof, 2008) were meeting with the intention to propel a new "force" in psychology. The result of these meetings was the establishment of transpersonal psychology, which was called by Maslow "the fourth force".

During the last 50 years, transpersonal researchers have been exploring and analyzing the relationship between body, mind, spirit and cosmos, whether through the creation of astonishing cartographies of the psyche, through rigorous empirical research, through psychotherapeutic practice or through their own spiritual experiences. Unfortunately, very little of the profound insights that were gained during the last 50 years of research managed to create an impact on mainstream psychiatry.

In *The Textboox of Transpersonal Psychiatry and Psychology*, Scotton, Chinen & Battista (1996) have brought together scholarly works which deal with the practical, theoretical and ethical implications of transpersonal research and therapy and provide an outline of a wide spectrum of multi-cultural perspectives on mental health. It seems that while there are a few studies about the intersection between psychiatry and spirituality, the term *Transpersonal Psychiatry* has barely been used outside the work of Scotton, Chinnen and Battista. *Transpersonal* psychiatry does not promote any particular belief system, but rather acknowledges that spiritual experiences and transcendent states are universal human experiences, and therefore worthy of rigorous, scientific study (Kasprow & Scotton, 1999). Kasprow and Scotton also write that "Inattention to these experiences and the roles they play in both psychopathology and healing constitutes a common limitation in conventional psychotherapeutic practice and research" (1999, p. 13).

Interestingly, after catapulting the current neurobiological paradigm, thanks to the return of psychedelic drugs to the spotlights of academic research and therapy, we are standing on the verge of yet another paradigm shift in psychiatry. The astonishing advancements that humanity has made during the last 50 years with regard to brain imaging, psychotherapeutic techniques and transpersonal research, has prepared the ground for the upcoming paradigm where psychedelics will take a central part in the treatment of a wide range of "disorders" like PTSD, depression, substance dependency, anxiety related to terminal illness and many more (Schenberg, 2018).

While modern psychology has been studying the therapeutic effect of altered states of consciousness since the days of William James in the beginning of the last century (Ryan, 2008), tribal cultures have been using psychedelic plants as sacramental tools for thousands of years. These plants have shaped the course of many established religions and are still used throughout the world today as part of religious ceremonies for many cultures (Schultes & Hofmann, 1979). In order for the emerging paradigm to bring the required transformation for the modern mental health system, we should take into account the lessons that were learned in the past with regard to therapeutic work with psychedelics. Bravo and Grob (1989) concluded their article "Shamans, Sacraments, and Psychiatrists" with the following lines (p. 127): "If American psychiatry is to embark on a renewed investigation of the potential therapeutic role of psychedelics, lessons of the traditional shamanic healers must be incorporated as an integral

component of such future clinical research".

During the early 1960s it became apparent that the quality and clinical effectiveness of psychedelic therapy were extremely dependent upon the patient's constitutional ('set') and environmental factors ('setting'). These factors, also termed *extrapharmacological factors*, vary considerably between different cultures, and especially between indigenous cultures and modern clinical research. For shamans, spirituality and healing are integrated parts of the same activity and "rituals are used to facilitate and structure the experience so that a focus of concentration allows the mind to enter more deeply into the implicit meaning" (Bravo & Grob, 1989, p. 126). The skills to be learned in the training of a shaman vary from one society to another, but usually include diagnosis and treatment of illness, supervising rituals, contacting spirits, interpreting dreams and gathering herbs. Since shamanism is based on values of compassion and service, ethical training is a key element in a shaman's education (Krippner, 2007). Contemporary therapies like behavior therapy, hypnotherapy, drug therapy, psychodrama and dream interpretation share many of the qualities of ancient and modern shamanic methods and practices (Krippner, 2007). "In regard to healing practices," writes Krippner, "shamans and psychological and psychiatric therapists demonstrate more similarities than differences" (2007, p. 19). These similarities, and of course the differences between the shamanic and psychological/psychiatric practices are emphasizing the important contribution the psychological study of shamanism (which is an important aspect of transpersonal psychology) has to offer to mental health professionals.

One of the main aspects that distinguish the transpersonal psychiatrist from the transpersonal psychologist is the application of psychopharmacological intervention. While at times medications can impede the patient in processing and integrating his experience (Scotton, Chinen & Battista, 1996), at other instances, psychopharmacological intervention may be necessary in order to prevent any harm from the patient and/or his surroundings and in order to ground the patient so he or she can begin with a psychotherapeutic process (Scotton, Chinen & Battista, 1996). In general, pharmacological intervention should be focused on balancing the level of symptoms, whether they be pain, depression, anxiety, or psychotic states, so that they can be integrated by the person in the service of growth (Scotton, Chinen & Battista, 1996). Every psychopharmacological intervention has side-effects to it, and therefore it is important that these will be minimized at all cost to provide the patient with "the appropriate combination of mental stability and agility" (Scotton, Chinen & Battista, 1996, p. 333). The transpersonal psychopharmacologist must be able to integrate spiritual knowledge and practice with meaningful psychopharmacological intervention, a task that clearly requires the knowledge of when each would be helpful. Actively manic patients (and their surroundings) for example, could be in a great risk without aggressive pharmacotherapy; however, the transpersonal psychiatrist could also introduce them to a specific spiritual practice and discuss the spiritual aspect of their crisis once they have become sufficiently clinically grounded (Scotton, Chinen & Battista, 1996).

Another aspect of psychiatric practice that is distinguished from psychological practice is the heavy responsibility that lies on the psychiatrist's shoulders, since in the case of a critical incident (a patient hurting himself or someone else for example) "the judgment of society comes down on them like a ton of bricks" (Powell, 2002, p. 7).

Dr. Andrew Powell, a psychiatrist, psychotherapist and the founding chair of the Spirituality and Psychiatry Special Interest Group (SPSIG) of the Royal College of Psychiatrists in the UK, has been actively promoting an open spiritual dialogue, practice and training in the psychiatric community for the last 20 years (Cook, Powell & Sims, 2009). In his article *Mental Health and Spirituality* Powell is suggesting to get spirituality on the agenda for psychiatrists in training in the UK and to make spiritual enquiry as relevant as taking a family or social history (Powell, 2002). The SPSIG has suggested a revision of the curriculum for the MRCPsych examination to the Royal College of Psychiatrists (Powell, 2002), where they detail the knowledge and skills that are required for the integration of spirituality into psychiatric practice.

Following are some of the major aspects that should be demonstrated by the psychiatrist according to the revised curriculum:

- Awareness of, and sensitivity to, the spiritual/religious historical development of the patient.
- Awareness of the patient's need to find a sense of meaning and purpose in life, his/her personal search for answers to deeper questions concerning birth, life and death and awareness of the difference between spirituality and religion as well as their inter-relatedness.
- Knowledge of spiritual crises, meditation, prayer and altered states of consciousness, including Near Death Experiences (NDEs).
- Knowledge of the spiritual significance of anxiety, doubt, guilt and shame as well as of the spiritual importance of love, altruism and forgiveness, and their relation to mental health.
- Familiarity with issues related to research, for example: the application of quantitative and qualitative research to the field of spirituality and psychiatric practice as well as the contribution of research to understanding the neuro-physiology and efficacy of prayer, meditation, forgiveness and love.
- Competence in the recognition of his/her own counter-transference responses to spiritual disclosures (Powell, 2002, pp. 10-12)

Another important emphasis Powell (2002, p. 11) makes is that:

Healing begins with the offering of love, a word that doesn't figure nearly enough in the lexicon of psychiatry. Compassionate love – spirituality in action – can only do good and mixes well with all other treatments that may be required.

Integrating such aspects into modern psychiatric practice are becoming more relevant than ever when taking into account the unique characteristics of psychedelic-assisted psychotherapy which is taking a major part in the current paradigm shift in psychiatry (Schenberg, 2018). One of the most intriguing aspects of psychedelic drugs is their ability to *enhance meaning* (Hartogsohn, 2018). Between two thirds to 86% of those who go through a psychedelic experience in a therapeutic setting consider them to be either one of the five most meaningful and spiritually significant experiences of their lives, or the single most meaningful experience (Hartogsohn, 2018). The 'Set' (psychological context) and 'Setting' (sociocultural context) of the experience are thus of crucial importance as their impact on the patient's experience is significantly multiplied by the effects of the drugs (Hartogsohn, 2018).

In conclusion, the current biological paradigm in psychiatry is failing to ease the suffering of hundreds of

millions of people. By merging modern psychiatry with transpersonal psychology and ancient as well as modern spiritual practices, we can help create a safe and supportive environment for psychiatric patients and thus greatly contribute to the wellbeing of both patients and psychiatrists in the emerging paradigm. In order to face the challenges of the modern mental health system, we might consider taking an example from tribal cultures where there are several “types” of shamans, and thus pave the way towards the professional establishment of sub-specialties in psychiatry, where transpersonal psychiatrists will work together with the patient towards healing and growth with humbleness, love and compassion.

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Our online distance-learning MSc in ‘Consciousness, Spirituality & Transpersonal Psychology’ provides **an intellectually-stimulating programme of study** which focuses on diverse topics around the nature of consciousness, the dynamics between psyche and soma, the psychology of self and higher states of being, and the psychological basis of spiritual and mystical practices. Our MSc programme is distinctive in valuing **experiential approaches to learning** and in encouraging students to incorporate insights from the programme into their own life journeys. In addition to a rigorous academic curriculum, modules exploring integral life practice, transpersonal approaches to research, and a research dissertation **focus on the practical application of learning**. The MSc programme consists of 180 course credits and most students complete the programme over **3 years**, studying part-time. The programme is run entirely online, and it is validated by Liverpool John Moores University in the UK.

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