The God Solution: Spirituality as a Coping Mechanism and Healing Tool for Mental Illness and Addiction

by

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For Dad
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Preface:

The topic of this thesis was conceived in January, 2012, during a visit to see my grandmother in West Palm Beach, Florida. I had been in recovery from alcoholism and Bipolar II disorder for almost a year, and during that time had become significantly more open to spirituality—to me, the presence of a Higher Power—in my life. As was the case with many others in recovery with whom I spoke for this project, I was initially uninterested in, even averse to, spirituality, because I thought it was closely related to organized religion. Over time, however, it became clear to me that spirituality was a much broader, all-encompassing concept.

On this trip, I met a 90-year-old man who had worked with my grandfather for many years, but had himself been sober for 50 years after returning from World War II. Both my grandfather and father succumbed to the disease of alcoholism and ultimately died from it. And here I had the opportunity to meet someone so early in my recovery who had lived more than twice my life sober. It was during this trip that I started to become hopeful about my future in recovery, convinced that I could live a happy and productive life without alcohol and other substances.

I attended numerous Alcoholic Anonymous (AA) meetings while I was in Florida, and one in particular left a strong impression. The meeting was a reading/discussion meeting, in which the group read a story from the AA book *Came to Believe*. Members would then share how they related to the story and share their own experiences of coming to believe in a Higher Power.¹

A local college student said he didn’t know why this group was his home group (primary group of attendance), because believing in a God was something he thought ridiculous given his atheist beliefs, and all the group ever spoke about was believing in God. He concluded by saying he would “keep coming,” (a very common AA phrase to describe giving the program a chance at success over time) and that for him, maybe the group and its members were his Higher Power.

A man in his early forties with over 20 years of sobriety said that spirituality to him was pretty simple: when he does good and puts others first, things get better; when he becomes selfish and ruminates on the problems in his life, he becomes resentful and things get worse. How simple and straightforward a philosophy that was, and it worked to keep this man sober for over 20 years. This reminded me of a quote I once heard attributed to Abraham Lincoln: “When I do good, I feel good; when I do bad, I feel bad, and that is my religion.”

Another man shared about having more traditional views on God and religion—he was a practicing Catholic most of his life—but it wasn’t until he became sober that he could actually establish a meaningful relationship with God.

A girl in her mid twenties said spirituality was something she continually experimented with in her six years of sobriety. She’d tried going to church and giving her Christian background a chance; she went through a phase of reading all about Buddhism and meditation; but finally she settled on believing in spirituality as love: taking care of herself (i.e. not drinking and doing drugs), helping other people in recovery and in life generally, and being grateful for all of the blessings she has in her life.
A former sleep neurologist-turned-mindfulness teacher spoke of how he always used to search for the answers—that knowledge was his religion—but that now he was a lot more comfortable with uncertainty and change. The more he could detach himself from expectations and his own desires, the better he could accept what God/his Higher Power/the Universe had in store for him. He had been a top doctor at a large hospital in the area years before, and had just started to get his life back on track. After attending an in-patient rehabilitation center, he was sentenced to four years in prison allegedly due to a former drug acquaintance using his DEA number to obtain and sell large amounts of narcotics, completely unbeknownst to him. In prison, he would meditate for upwards of four hours per day, accepting his situation as a way of getting in touch with his “Inner Inmate,” as he affectionately called his ego, rather than feeling victimized for what had happened.

In this short one-hour AA meeting, I was exposed to a wide variety of ideas about spirituality, faith, and God/Higher Powers that, although very different from one another, had helped people stay sober, often for very long periods of time. This got me thinking about how such a varied but apparently beneficial therapeutic tool such as spirituality could be examined and promoted within the wider field of mental health treatment. I was in for a rude awakening, later discovering that the medical community pays little attention to spirituality as a complementary form of therapy and healing. The purpose of this thesis is to delve into a deeper analysis of the phenomenon I witnessed at the Came to Believe meeting in Florida—that spirituality can be a very important part of recovery from mental illness and addiction—and understand its place in mainstream treatment.
I set out to address a number of questions that are not frequently addressed by the medical community today: What is spirituality, especially in the context of mental health care, and why isn’t it actively discussed more? Does spirituality help patients suffering from mental illness and addiction in their recoveries? If so, how does it work and how is it balanced with other treatments? As these conditions are chronic—treatable but not curable—how do patients manage to maintain their spirituality facing the constant challenges their illnesses present? Finally, if in fact spirituality is beneficial for mentally ill and addicted patients, what are the possibilities and limitations of incorporating it into the current treatment paradigm?
Introduction:

Despite the rapid advancement of modern medicine over the past two centuries, the causes of and treatments for mental illness and addiction still remain incompletely understood and far from 100% successful. According to the Mayo Clinic, numerous factors, including inherited traits, life experiences, and biological factors (such as traumatic brain injury and exposure to viruses or toxins in the womb), may affect brain chemistry linked to mental illness.² Under its “Treatments and drugs” section, the Mayo Clinic lists medications (obtained through prescription by a psychiatrist), psychotherapy (such as cognitive behavioral therapy or dialectical behavioral therapy usually provided by clinical psychologists), brain-stimulation treatments (such as electroconvulsive therapy or transcranial magnetic stimulation), and hospitalization and residential treatment programs (which typically result in some combination of the previous three treatments being used).³ There is mention of “12-step programs such as Alcoholics Anonymous (AA)” under the “Substance abuse treatment” section, but no information is provided about how AA and other 12-step programs are fundamentally spiritual programs, aimed at getting recovering alcoholics/addicts in touch with “God as we understood Him” (Step 3).⁴ Surprisingly, the words “religion” and “spirituality” do not appear once in the Mayo Clinic’s discussion of treatments.

for mental illness and addiction, and the Mayo Clinic is one of the leading medical research institutions in the United States.

If current treatments were more successful, the lack of focus on spirituality as an accepted treatment modality might not be a significant issue, but most “established” treatments, including psychiatric medications, have at best a slightly over a 50% success rate. Unsuccessfully treated mental illness is a huge public health problem, costing billions of dollars yearly in work absenteeism, hospitalization costs and disability payments, in addition to enormous human suffering.

This thesis, through a combination of extensively examining both historical and contemporary literature on the subject, as well as dozens of interviews conducted with psychiatrists and psychologists, clergy and religion scholars, and, most importantly, recovering mental illness and addiction sufferers themselves, seeks to examine the misunderstood topic of spirituality as a form of therapy and healing for mental illness and addiction. The following is essential background information about the three groups—medical, clergy, and patient—of individuals interviewed.

In the medical group, I interviewed eight psychiatrists, one clinical psychologist, and two mental health counselors (one of whom was a student in training). Four of the psychiatrists were still practicing at Yale, two were retired and had previously practiced at Yale, and the remaining two were from Mt. Sinai School

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of Medicine and the Community Health Center in Middletown, CT. The psychologist was a practicing psychotherapist at Wesleyan University, the mental health counselor was a mindfulness workshop leader at the Institute of Living in Hartford, and the other a mental health counselor-in-training at Southern Connecticut State University. From what I read about the general views of psychiatrists toward spirituality and heard from the psychiatrists I interviewed, it became apparent that these psychiatrists were more progressive and informed when it came to integrating spirituality into therapy. The non-psychiatrists were also very supportive of spirituality, but that was less surprising than the attitudes of the psychiatrists.

Similarly, the clergy interviewed were also representative only of the relatively small Yale and Wesleyan bubbles I was in during the research and writing processes of this thesis. I interviewed six clergy from Yale and Wesleyan, and two clergy who were not affiliated with either institution: Rev. Maner Tyson, a Baptist minister from Waterbury, CT and Rev. Katie Norris, a minister at the West Shore Unitarian Universalist Church in Rocky River, OH. I connected with Rev. Tyson through a mutual friend and Rev. Norris through a timely post on the National Alliance on Mental Illness (NAMI) Facebook page about religion and mental illness. It is important to note that all of the clergy I interviewed were either from liberal faith traditions, liberal regions of the country, or both, which likely accounts for the fact that none of them denied the reality of mental illness and addiction, and all were in favor of patients seeking professional medical treatment.

Finally, the patient population for this thesis was contacted either through Alcoholics Anonymous (AA) meetings or Depression Bipolar Support Alliance
(DBSA) meetings. In total, I interviewed 15 patients, ten males and five females. The requirement to be interviewed was having at least one full year in recovery, either sober (substance-free) if an alcoholic/addict or stable and not hospitalized if mentally ill. Many of the patients interviewed happened to be dual-diagnosis, i.e. both mentally ill and alcoholic/addicted, which offered a unique perspective on the similarities and differences between mental illness and addiction.

The goal of the thesis is to better understand the role that spirituality currently plays in mental health treatment and to determine how this treatment modality can be better integrated into the current treatment paradigm, if it is shown to be beneficial. The thesis aims to do that by answering a number of specific questions: First, what is spirituality, especially in the context of mental illness and addiction treatment? Second, how does spirituality, if at all, assist the mentally ill and addicted in their recovery? Third, how, once entered into recovery (i.e. actively seeking treatment), do the mentally ill and addicted maintain their spirituality and faith in the most challenging times? Fourth, if spirituality is in fact a beneficial treatment, why has the medical community not paid adequate attention to spirituality up to this point, and how can it be better integrated into the current treatment paradigm?

To answer these questions, the thesis is divided into five paragraphs. Chapter one lays a groundwork for the thesis by setting out definitions of the terms “spirituality,” “mental illness,” and “addiction,” while also looking at some of the modern history of each. Chapter two examines some of the general benefits to health that have been documented for spirituality, some of which, I argue, have similarities to mental health and can be extended to recovery from mental illness and addiction.
Chapter three explores the different types of spirituality practiced by the patients interviewed for this thesis, as well as the similar effects those different spiritual beliefs and practices had on patients’ lives. Chapter four delves into the existential question of how patients can maintain spirituality when facing the hardest times in their recovery, such as cravings, mental illness episodes, difficult life circumstances, and other stressors. Finally, chapter five looks at the reasons the medical field, especially psychiatry, has been apprehensive or even averse to incorporating spirituality into patient care, and attempts to identify some ways to change this in the future.

A close examination of these questions is important and relevant to society today for a number of reasons. First, without knowing exactly why—like all other forms of mental illness treatments, including medications and psychotherapy, for that matter—spirituality appears to work for many people. There are millions of recovering alcoholics and addicts, who believe that working the 12 Steps of AA and coming to believe in a God, or a Higher Power of one’s own understanding, is the only thing that can keep them sober. In many cases, where detoxes, rehabs, and psychotherapy have failed (i.e. the individual relapsed and began drinking or using drugs again), belief in God has worked and led to extended sobriety. In “The Doctor’s Opinion,” the first chapter in the main text of AA, *Alcoholics Anonymous*, psychiatrist and addiction specialist Dr. William Silkworth, who tended to AA co-founder Bill Wilson while he was in the hospital in 1934, describes what those in AA refer to as the “spiritual solution,” as well as the limitation of modern medicine to match it:
[The ideals of recovering alcoholics] must be grounded in a power greater than themselves, if they are to re-create their lives...Unless this [still-active alcoholic] can experience an entire psychic change there is very little hope for his recovery...Once a psychic change has occurred the very same person who seemed doomed, who has so many problems he despaired of ever solving them, suddenly finds himself easily able to control his desire for alcohol, the only effort necessary being that required to follow [the 12 Steps]...We physicians must admit we have made little impression upon the problem as a whole. Many types do not respond to the ordinary psychological approach.7

In addition to the mysterious effectiveness of spirituality in facilitating or enhancing recovery from addiction, this thesis seeks to extend study to patients suffering from mental illness as well. This thesis will explore whether the same principles and effects of spirituality apply to recovery from mental illness.

Secondly, this topic is important to explore because the field of mental health treatment is at a crossroads, if not already past it, of a concerning paradigm shift. That crossroads is, as former President of the American Psychiatric Association Stephen S. Sharfstein put it, the shift from the “biopsychosocial model [of psychiatric treatment] to...the bio-bio-bio model. A ‘pill and an appointment’ has dominated treatment.”8 In his 2010 book Unhinged: The Trouble with Psychiatry, psychiatrist Daniel Carlat of Tufts Medical School writes that psychiatrists “know a good bit less about what we are doing than you might think.”9 If Carlat’s claim is correct—and his book thoroughly explains the limited science psychiatrists do know about how psychotropic medications affect the brain—why is this shift occurring,

7 Alcoholics Anonymous, xxix.
overshadowing and abandoning the potential healing benefits of spirituality and other complementary therapies? This thesis addresses this question and also describes the potential benefits this therapeutic modality can have for mentally ill and addicted patients.
Chapter 1: A Brief History and Definition of Spirituality, Mental Illness, and Addiction

Any project about the effects of spirituality on mental illness and addiction must begin with a definition of these ambiguous terms. Throughout the course of this project, I asked over 30 individuals, including doctors, clergy, and patients, what their definition of spirituality was, and received different responses from each. On the one hand, this is workable from a clinical perspective. Even if each patient has their own definition of spirituality, discussions can be personally tailored between the patient and the mental health professional to deal with the specifics of a person’s unique experience. On the other hand, without some unified definition of the term, it is very difficult to conduct research on its effects.

This thesis is not meant to be a semantic analysis of religion and spirituality. A large and ever-growing literature exists on the definitional and practical debate between religion and spirituality, and academic conferences are held to better understand them. As recently as October, 2012, the Social Science Research Council published a working paper entitled, “Mapping A Field: Why and How to Study Spirituality,” attempting to synthesize historical and contemporary thinking on the topic. Its point on the difficulty of defining spirituality is well taken:

Spirituality…is challenging to study, not so much because it lacks a definition (or a relational counterpart, like “religion,” to make it meaningful), but because it suffers from an excess of definitions, each of which shapes a particular set of discourses and empirical investigations into various social phenomena. Scholars and journalists, religious and secular people, clergy and laymen, and even politicians invoke spirituality in numerous ways.\(^\text{10}\)

Since this thesis focuses on the role of spirituality in mental health, I will propose a definition of the term for this thesis by narrowing the “excess of definitions” to only those related to the mental health field. Before doing so, however, it is important to understand the evolution of thought surrounding the term and how certain prominent 20th century psychological thinkers influenced its wider reception in society with their views.

**Early Years: In the Shadow of Freud**

The field of spirituality in mental health is a relatively recent field of study, tracing its origins back to the “founder of American psychology,” William James, at the beginning of the 20th century.\(^{11}\) Better known for his 1890 work, *The Principles of Psychology*, James’ later influential writings on religion and spirituality are not often mentioned in introductory psychology textbooks.\(^{12}\) To gain an understanding of spirituality in mental health, it is helpful examine James’ 1902 book, *The Varieties of Religious Experience*.\(^{13}\)

In Lecture II, “Circumscription of the Topic,” of James’ *Varieties*, he presents his “own narrow view of what religion shall consist in,” because of the difficulty of covering the whole field of religion.\(^{14}\) It is interesting to note that James found himself facing the very same definitional predicament in 1902 as anyone examining

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12 A search through the indexes of five introductory psychology textbooks yields mentions only of James’ *Principles of Psychology* and the James-Lange Theory that emotions are the result of physiological responses, nothing of his works on faith, such as *The Varieties of Religious Experience*.
14 Ibid., 34.
the topic today. As James saw it, “we are struck by one great partition which divides
the religious field. On the one side lies institutional, on the other personal religion.”

Institutional religion consists of “worship and sacrifice, procedures for working on
the dispositions of the deity, theology and ceremony and ecclesiastical organization,”
while personal religion, the focus of his book, consists of “the inner dispositions of
man himself which form the centre of interest, his conscience, his deserts, his
helplessness, his incompleteness.” While James did not use the term “spirituality”
in his writings, his examination of “personal religion” was something unique that
would ultimately align with modern conceptions of spirituality.

Very soon after the time of James’ writing on the subject a perhaps equally
influential thinker in the field of psychology was developing arguments against the
practice of religion, regardless of institutional or personal practice. That thinker was
Sigmund Freud, who over the course of the early 20th century wrote widely read
polemics against religion. In 1907, Freud published his first paper on the topic,
“Obsessive Actions and Religious Practices,” reflecting on the similarities between
the ceremonies of obsessive neurotics and the ceremonies of religious believers.
Over the next 30 years until his death, Freud continued to write about what he saw as
the opposition between religion and sound mental health. The Future of an Illusion, a
short book of Freud’s published in 1927, further elaborated on his anti-religious
views:

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15 Ibid.
16 Ibid.
Religion would thus be the universal obsessional neurosis of humanity....If this view is right, it is to be supposed that a turning-away from religion is bound to occur with the fatal inevitability of a process of growth....If, on the one hand, religion brings with it obsessional restrictions, exactly as an individual obsessional neurosis does, on the other hand it comprises a system of wishful illusions together with a disavowal of reality, such as we find in an isolated form nowhere else but amnesia, in a state of blissful hallucinatory confusion...18

The influence of Freud’s ideas in steering the mental health field away from examining religion and spirituality as therapeutic tools is not to be understated. As psychiatrist Peter Kramer notes in his critical biography of Freud, until the 1980s, Freud’s ideas were dominant:

I trained at Harvard Medical School in the 1970s. Harvard was then such a bastion of orthodoxy that the faculty had no need to style itself as Freudian. There was no distinction between studying psychiatry and following Freud.19

Despite the dominance of Freudian theory and anti-religious thought for much of the 20th century, a program for recovering alcoholics, now known as Alcoholics Anonymous (AA), began to emerge in 1935. Though there had previously existed temperance movements, AA took no political stance on alcohol or outside issues; rather, its primary purpose, co-founders Bill W. and Bob S. wrote, “is to stay sober and help other alcoholics to achieve sobriety.”20 The program consisted of 12 steps, only the first of which mentioned the word “alcohol.” The remaining 11 steps sought to develop in the alcoholic a relationship with God, or a Higher Power, without which

chances at long-term recovery were slim. In chapter two of the main text Alcoholics Anonymous, “There is a Solution,” the importance of spirituality is made very clear:

There is a solution [to alcoholism]…there was nothing left for us but to pick up the simple kit of spiritual tools laid at our feet…we have had deep and effective spiritual experiences* which have revolutionized our whole attitude toward life, toward our fellows and toward God’s universe…[T]here is no middle-of-the-road solution…we had but two alternatives: One was to go on to the bitter end, blotting out the consciousness of our intolerable situation as best we could; and the other, to accept spiritual help.21

While this view of spirituality as an essential component of recovery may not have had much following in medical circles, which at the time largely subscribed to Freudian ideas, Bill W. received a letter from prominent Swiss psychiatrist Carl Jung in January, 1961, in which Jung acknowledged the power of spirituality. Jung wrote that he saw craving for alcohol in alcoholics as “the equivalent, on a low level, of the spiritual thirst of our being for wholeness, expressed in medieval language: the union with God.”22 He further noted that in Latin alcohol is spiritus, and so the formula of “spiritus contra spiritum” (approximately translated to “spirituality against spirits of the alcoholic sort”) is needed in order to find true spiritual fulfillment.23

Alternatives to Freud: Frankl Paving the Way

While Freud’s negative views toward spirituality were considered the mainstream position of the mental health field for most of the 20th century, there was an alternative group of thinkers that maintained the importance of some form of spirituality in living a purposeful and healthy life. One of the earliest advocates from

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23 Ibid. 19.
this group was Austrian psychiatrist Viktor E. Frankl, who published his influential book, *Man’s Search for Meaning*, in 1946. Frankl was a successful psychiatrist practicing in Austria when he and his family were deported to Auschwitz for being Jewish. It was there, facing treacherous living conditions and inhumane treatment that Frankl came to believe that “life holds a potential meaning under any conditions, even the most miserable ones.” He realized in the concentration camp that “Man [sic] can preserve a vestige of spiritual freedom, of independence of mind, even in such terrible conditions of psychic and physical stress.” What was this “spiritual freedom” that Frankl identified? Why was it important and how could it be maintained during difficult times? His broad definition was essentially the ability to find meaning in life, and he created the term “logotherapy” to describe his philosophy:

*Logos* is a Greek word which denotes “meaning.” Logotherapy…focuses on the meaning of human existence as well as on man’s [sic] search for such a meaning. According to logotherapy, this striving to find a meaning in one’s life is the primary motivational force in man [sic]. That is why I speak of a will to meaning in contrast to the pleasure principle (or, as we could also term it, the will to pleasure) on which Freudian psychoanalysis is centered, as well as in contrast to the will to power on which Adlerian psychology, using the term “striving for superiority,” is focused.

Logotherapy, in a sense, is a form of spirituality, or a method for getting in touch with spirituality in one’s life. Frankl’s “search for meaning,” is an important component of the definition of spirituality that has parallels seen in earlier thinkers, such as James and Jung, as well as later thinkers.

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25 Ibid., 86.
26 Ibid., 121.
Dr. Herbert Benson, a cardiologist at Harvard University, contributed to a deeper understanding of spirituality with his 1975 work, *The Relaxation Response*. As a cardiologist, Benson was primarily concerned with physical health, specifically that of the heart. However, he thought that the mainstream medical establishment paid little attention to “the relationship between mind and body,” and that changing the way humans think could positively affect their health.27 The book primarily talks about the practice of the Relaxation Response, a form of meditation consisting of four basic elements: 1) a quiet environment, 2) an object to dwell upon, 3) a passive attitude, which “appears to be the most essential factor in eliciting the Relaxation Response,” and 4) a comfortable position.28 Benson studied various practices similar to the Relaxation Response, including Transcendental Meditation and Yoga, and found that the physical benefits of eliciting the Response included decreased “oxygen consumption, heart rate, respiratory rate, and blood pressure,” all indications of a trend toward better physical health.29

The Relaxation Response itself does not have to be spiritual per se, though the practice of becoming calmer and healthier could very well be considered a way of finding meaning in life. In his 1984 sequel, *Beyond the Relaxation Response*, Benson argues for something more powerful than just the Relaxation Response alone, which he calls the “Faith Factor.”30 The Faith Factor combines the Relaxation Response with a person’s deepest personal beliefs. Benson notes that this concept is not

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28 Ibid., 85-6.
29 Ibid., 115.
necessarily an original one, but rather is a new kind of “package” that includes both meditation and “a deeply held set of philosophical or religious convictions.” What Benson contributes to the understanding of spirituality is that it is not simply a belief that one holds, such as there being a loving God that cares for humankind, or that the purpose of life is to help others. Rather, spirituality is the practicing and deepening of those beliefs through meditation, prayer, or other positive action. This is consistent with Frankl’s conception of spirituality as a search for meaning as opposed to a concrete discovery of meaning. The practice of searching through meditation or prayer is significant, because when one stops searching, the physical, and presumably the mental, effects of spirituality that Benson noted cease to occur.

Finally, two other modern thinkers, who focus primarily on addiction, provide important insight into spirituality in mental health. Dr. Abraham J. Twerski is both a rabbi and a psychiatrist, who has spent much of his life treating addiction patients. As Twerski sees it, “capacities that are unique to humans [such as the capacities to learn from history, contemplate the purpose of existence, think of ways to better ourselves and then implement them, and make moral decisions] may be said to constitute the spirit.” Ernest Kurtz, an unofficial historian of AA, adds another important idea that spirituality is not a tool to strive for perfection, but rather a tool for understanding and accepting our imperfection:

Spirituality begins with the acceptance that our fractured being, our imperfection, simply is: There is no one to “blame” for our errors—neither ourselves nor anyone nor anything else. Spirituality helps us first to see, and

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31 Ibid., 6.
then to understand, and eventually to accept the imperfection that lies at the very core of our human be-ing.33

Kurtz’ idea of the “spirituality of imperfection” is especially important, as the conditions this thesis considers with regards to spirituality are mental illness and addiction, chronic conditions that pose significant challenges to the lives of those suffering from them. This is similar to a distinction James makes between the “healthy-minded” and “sick souls,” the former of which only need to be spiritually “born” once in order to be happy, the latter of which need to be “twice-born.”34

Further, this is something that was confirmed by many of the patients with whom I spoke for this project, who mentioned having a personal spirituality different from the religion they were raised in because their views changed after their illness manifested.

To reiterate, up to this point, we have seen that spirituality is a multifaceted combination of theory and practice. The 20th century thinkers who held open-minded views toward spirituality developed it into a very different concept than the formal religion to which Freud vehemently objected as fostering neurotic tendencies. The characteristics of spirituality that were defined by progressive thinkers during this period included: a focus on personal rather than institutional practices (James), a thirst for wholeness (Jung), a search for meaning (Frankl), the practice of meditation and prayer integrated with philosophical and religious beliefs (Benson), a utilization of unique human capacities for complex thought and meaning (Twerski), and a reckoning with and acceptance of our imperfections (Kurtz).

34 James, The Varieties of Religious Experience, 155.
Contemporary Spirituality

In the past two decades, a resurgence of discussion and scholarship has occurred around spirituality in mental health. In 1998, Duke University founded the Center for Spirituality, Theology, and Health, “focused on conducting research, training others to conduct research, and promoting scholarly field-building activities related to religion, spirituality, and health.” Dr. Harold G. Koenig, the director of the program, has been a pioneer in the field and authored hundreds of scholarly articles and dozens of books on the intersection between spirituality and health. In his 2007 book, *Spirituality in patient care: why, how, when and what*, Koenig acknowledges the difficulty of defining spirituality specifically enough so that it doesn’t include everything from a sexual experience to eating a meal to riding the bus, while at the same time not placing so many constrictions on it that certain individual practices are not considered spiritual. He favors the definition of spirituality, created by religion and psychology scholar Kenneth Pargament, as “a search for the sacred.” The “sacred” can, but does not have to be, God or a Higher Power, or it could be a form of ultimate meaning or truth in someone’s life.

In 2001, Dr. Christina Puchalski of The George Washington Institute for Spirituality and Health (GWish) wrote an article entitled “The role of spirituality in health care.” In it, she established a definition of spiritual from the perspective of

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37 Ibid., 40.
doctors and other caregivers. Spiritual or compassionate care, she wrote, “involves serving the whole person—the physical, emotional, social, and spiritual.” Puchalski also included a helpful description by Dr. Rachel Naomi Remen on the three different ways of seeing life:

Helping, fixing, and serving represent three different ways of seeing life. When you help, you see life as weak. When you fix you, you see life as broken. When you serve, you see life as whole. Fixing and helping may be the work of the ego, and service the work of the soul.

Serving is an especially beneficial way of viewing care and support for individuals suffering from mental illness and addiction. While there are some effective therapies, such as medication and psychotherapy, for alleviating some of the pain these conditions cause, ultimately they are chronic and incurable. For this reason, acknowledging that there are no quick and easy solutions to these mental conditions, and listening to and trying to understand a patient’s individual experience, are the best things caregivers, medical or otherwise, can do.

Even more recently, in 2008, the U.S. Veterans Affairs Hospitals implemented a mandatory “spiritual assessment” to be asked to patients in the hospital. The guidelines for the policy change were thorough, including definitions of “spiritual,” and “holistic care,” among other terms, as well as the important guideline that “the choice to receive spiritual or pastoral care, the choice to complete a spiritual assessment, and the choice to participate in a religious or spiritually-based treatment

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39 Ibid., 352.
40 Ibid.
41 Department of Veterans Affairs, “Spiritual and Pastoral Care Procedures,” VHA Handbook 111.02, July 18, 2008.
program always remains the private choice of the veteran.” Thus, although it is mandatory for hospital staff to ask veterans if they want to participate in the spiritual screening process, spirituality and religion are not being forced upon anyone. Instead, the screening process is a helpful measure to have in place to ensure that pastoral care is not overlooked for those patients for whom spirituality is important.

To conclude this section, the extended definition of “spirituality” provided by the Veterans Health Administration seems to be sufficiently inclusive of the other important definitions noted throughout this chapter:

Spirituality may be used in a general sense to refer to that which gives meaning and purpose in life, or the term may be used more specifically to refer to the practice of philosophy, religion, or way of living…The concept of breathing captures the meaning of the word “spiritual” in relation to that which is or is not “life giving.” Therefore, spirituality may positively or negatively affect one’s overall health and quality of life.  

This is the definition of spirituality that will be used throughout the rest of this thesis, except when referring specifically to a different definition provided by one of the interview subjects in which case that will be noted.

**Defining Mental Illness and Addiction**

Setting out an encompassing and unified definition of spirituality is only part of the task of a thesis examining the role of spirituality in mental illness and addiction treatment. Another crucial task is defining mental illness and addiction. The subjects interviewed in the patient category for this thesis generally fell into one of two mental illness diagnoses (as well as addiction, which is defined separately): major depressive disorder and bipolar disorder. Any other mental illnesses, such as dysthymia or

42 Ibid., 1.
43 Ibid., 2.
posttraumatic stress, mentioned by a minority of patients in their interviews for this project, can be understood as conditions related to one or both of the two primary mental illnesses examined.

Mental illness is difficult to define, as distinguishing between mental normality and mental pathology has always been a highly subjective process. The evolution of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, now in its fourth edition after six revisions, has been rife with controversy over diagnoses. Since its first publication in 1952, soon after Freudian views became the gold standard for the field of psychiatry, there have been so many additions and redactions of diagnoses that understanding what mental illness actually is has become ever more challenging.

In his 2010 *Wired* magazine article “Inside the Battle to Define Mental Illness,” psychotherapist Gary Greenberg details the ebb and flow of accepting and then rejecting various “mental illness,” diagnoses, demonstrating that significant cultural and societal components are involved in deciding what is an illness and what is not:

It happened in 1980, when psychoanalysts objected to the removal of the word neurosis—their bread and butter—from the *DSM*-III. It happened in 1973, when gay psychiatrists, after years of loud protest, finally forced a reluctant APA to acknowledge that homosexuality was not and never had been an illness. Indeed, it’s been happening since at least 1922, when two prominent psychiatrists [August Hoch and John MacCurdy] warned that a planned change to the nomenclature would be tantamount to declaring that “the whole world is, or has been, insane.”

While some conditions once considered to be mental illnesses have been redacted from the *DSM*, a much more concerning trend exists in the creation of more and more

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diagnoses and subtypes of diagnoses. Some psychiatrists, who wished to remain anonymous in Greenberg’s article due to potential punishment by the American Psychiatric Association (APA), feel the field is being turned into a “laughing stock” with the fabrication of more and more diagnoses each time the DSM is revised.45

Some authors, including Boston College Professor of Sociology David A. Karp, and Tufts University Psychiatrist Daniel Carlat, have openly challenged the integrity of the DSM in their respective books, *Is It Me or My Meds?*, and *Unhinged*. Karp notes that the DSM has gone from having 60 psychiatric disorders in 1952, to 120 diagnostic categories in 1968, to over 350 diagnoses in the current DSM.46 Carlat criticizes many aspects of the field of psychiatry, from deceptive communication with patients by psychiatrists to over-prescribing and the dominance of psychopharmacology to pharmaceutical and insurance company influence.47 He argues for reforms such as better training programs for psychiatrists that emphasize all aspects of care—not just medication treatment—as well as regulations that prohibit pharmaceutical companies from lavishing money and gifts on psychiatrists so as to eliminate the significant conflicts of interest that currently exist.48 Fortunately, some progress has been made in prohibiting pharmaceutical companies from courting physicians since Carlat wrote an influential piece, “Dr. Drug Rep,” in the New York

45 Ibid.
However, the issue of insurance reimbursement is still a significant issue. Since the effects of medications are generally faster and easier to quantify than talk therapy (within which category spirituality would fall), it is easier for psychiatrists to get reimbursed for prescribing medications and it is less time consuming for them to administer.\textsuperscript{50}

It is not just a fringe group of outsiders criticizing the psychiatric establishment either. None other than the two psychiatrists who chaired the revision committees of the current and previous DSM, Allen Frances and Robert Spitzer, have staunchly challenged the newest revision of the DSM, the DSM-5, which has been approved for publication in May 2013. Even though the DSM-IV offers a definition of a mental disorder, former chairperson Frances told Greenberg, “there is no definition of a mental disorder. It’s bullshit. I mean, you just can’t define it.” The definition offered in the DSM-IV is the following:

A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.\textsuperscript{51}

The clarification is offered: “this syndrome or pattern must not be merely an expectable or culturally sanctioned response to a particular event, for example,


\textsuperscript{51} Diagnostic and Statistical Manual of Mental Disorders, \textit{4\textsuperscript{th} Ed. Text Revision}, DSM-IV-TR (Arlington, VA: American Psychiatric Association, 2000), xxxi.
mourning the death of a loved one.” Further, regardless of its cause, a mental disorder must be considered, “a manifestation of a behavioral, psychological, or biological dysfunction in the individual,” which again raises the question of what is dysfunctional and what is not.

Despite the ongoing disputes in the psychiatric community over the legitimacy of certain DSM diagnoses, such as pediatric bipolar disorder and adult ADHD, the two DSM-IV-TR definitions of the mental illnesses examined in this thesis are less controversial. I specifically wanted to choose categories of mental illness that are very common in the general population. According to the National Institute of Mental Health (NIMH), approximately 20.9 million American adults, or about 9.5 percent of the U.S. population age 18 and older in a given year, have a mood disorder, e.g. depression or bipolar disorder. I specifically did not look at schizophrenia and severe obsessive-compulsive disorder (OCD) because open support groups for these conditions could not readily be found. Some literature, however, including a recent Op-Ed piece in the New York Times written by Elyn Saks, a schizophrenic professor

52 Ibid.
53 Ibid.
54 Carlat, Unhinged, 150: “In terms of diagnostic controversy, adult ADHD is the mirror image of pediatric bipolar disorder. In bipolar disorder, the controversy revolves around whether we can accurately apply an adult diagnosis to children. In ADHD, the question is whether we can apply what has traditionally been a childhood diagnosis in adults.”
55 Over the summer of 2012 I searched for mental illness support groups and the one I was able to find easiest was the Depression Bipolar Support Alliance (DBSA). While support groups for other mental illnesses surely exist, they do not seem as prevalent as DBSA, which had chapters both in the New Haven, CT area where I was researching at the time, and Skillman, NJ, where I live when not at school.
of law at the University of Southern California, mentions that spirituality and a belief in God may help some schizophrenics in their recoveries.\textsuperscript{56}

The DSM definition of Major Depressive Disorder is as follows:

Major Depressive Disorder is characterized by one or more Major Depressive Episodes…The essential feature of a Major Depressive Episode is a period of at least 2 weeks during which there is either depressed mood or loss of interest or pleasure in nearly all activities…The individual must also experience at least four additional symptoms from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts.\textsuperscript{57}

The definition of Bipolar Disorder is more complicated. The DSM-IV distinguishes between Bipolar I Disorder and Bipolar II Disorder in that Bipolar I Disorder entails having one or more Manic Episodes, usually accompanied by Major Depressive Episodes as well, while Bipolar II Disorder instead entails the experience of at least one Hypomanic Episode.\textsuperscript{58} Since the characteristics of a Major Depressive Episode are included in the definition above, below is the DSM definition of a Manic Episode, for the purpose of being able to distinguish between Bipolar I and Bipolar II Disorders:

A Manic Episode is defined by a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood. This period of abnormal mood must last at least 1 week (or less if hospitalization is required). The mood disturbance must be accompanied by at least three additional symptoms from a list that includes inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities with a high potential for painful consequences.\textsuperscript{59}


\textsuperscript{57} DSM-\textit{IV-TR}, 345, 349.

\textsuperscript{58} Ibid., 345.

\textsuperscript{59} Ibid., 357.
The definition of a Hypomanic Episode is the same as a Manic Episode except it specifies that symptoms must be experienced for “at least 4 days,” (instead of 1 week) and that the inflated self-esteem and grandiosity must be “nondelusional,” i.e. not detached from reality.\(^{60}\) I interviewed both Bipolar I and Bipolar II patients for this project, and will hereafter refer generally to both cases simply as “bipolar disorder,” because the mania versus hypomania distinction has little bearing on the ability to incorporate healthy spirituality into one’s life.

As previously discussed, the *DSM* is a far from agreed upon diagnostic tool. However, an important aspect of the mentally ill patients interviewed for this thesis who suffered from depression and bipolar disorder is that they had accepted their diagnoses and identified themselves as mentally ill based on these diagnoses. These diagnoses were not accepted due to the influence of pharmaceutical companies or psychiatrists, though almost all of the patients interviewed saw psychiatrists and took prescribed medications to alleviate symptoms of their illnesses. Rather, these patients perceived their illnesses along the lines of the National Alliance on Mental Illness (NAMI) definition, as “condition[s] that disrupt a person’s thinking, feeling, mood, ability to relate to others and daily functioning.”\(^{61}\)

**Defining Addiction: Medical versus Practical**

Defining addiction seems to be an easier task, especially considering that for this thesis, I only spoke to individuals who had been in recovery (i.e. sober and substance-free) for at least one year. The section devoted to Substance-Related

\(^{60}\) Ibid., 365.

Disorders in the *DSM* is over 100 pages long, and sets out specific criteria for addiction to all different substances, from alcohol to narcotics to cocaine. While such criteria may be valuable in determining whether an individual who exhibits heavy alcohol or drug use but is in denial of being an alcoholic or addict (hereafter “addict,” which includes those who identify as “alcoholics”) is actually so, it is not important for this thesis for two reasons. The first is that no one interviewed denied being an addict. Many shared that they had denied being an addict for a long time prior to entering into recovery, but since admitting they were an addict, they no longer had any doubts. The second is that, unlike the *DSM’s* very compartmentalized, substance-by-substance approach to these “substance-related disorders,” such one-dimensional substance abuse was rarely seen. Most addicts interviewed were like James S., a 23-year-old man who said, “I had tried heroine, cocaine, crack. I had tried almost every drug because alcohol and marijuana weren’t strong enough.”

Many others shared something along the lines of trying any substance that could help them “escape” reality before returning to primarily drinking alcohol. The desire to feel other than how they felt, to avoid dealing with the problems in their lives, and, ironically, to give themselves a false sense of being in control of their drinking, drug use and lives in general, were some of the main reasons the addicts interviewed for this thesis continued to abuse alcohol and drugs, not because they had a “disorder” of being addicted to only one substance.

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63 James S. Interview by author, 28 December 2012, Skillman.
Definitions of Addiction from the Recovery Community

The recovery community, i.e. the group of doctors, counselors, and patients/addicts themselves familiar with 12-step spiritual programs of recovery, offers a definition of addiction that has a spiritual component not included in either the *DSM* or other standard medical sources. Before discussing the spiritual aspect of addiction, it should be stated that there is general agreement upon the physical and mental aspects of addiction, so for those two aspects, a standard medical definition, such as the one offered by the National Council on Alcoholism and Drug Dependence (NCADD), is sufficient:

Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic: impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial.64

The last trait of denial ties in very well with the spiritual aspect of addiction. Bill W. wrote in *Alcoholics Anonymous*, “First of all, we had to quit playing God,” which referred to the delusion of control that many addicts live under, and the denial that they have an addiction problem.65 Rabbi and author Rami Shapiro echoed Bill W. in his book, *Recovery*, in which he defines addiction as “a state of mind committed to maintaining the illusion of control.”66

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65 *Alcoholics Anonymous*, 62.
It is in the very beginning of *Alcoholics Anonymous*, in a chapter entitled “The Doctor’s Opinion,” that the “spiritual malady,” as it is often called in AA, is described:

We believe…that the action of alcohol on these chronic alcoholics is a manifestation of an allergy: that the phenomenon of craving is limited to this class and never occurs in the average temperate drinker…In nearly all cases, [the recovering addict’s] ideals must be grounded in a power greater than themselves, if they are to re-create their lives…something more than human power is needed to produce the essential psychic change.\(^{67}\)

The “phenomenon of craving,” was elaborated on by Mike G., an alcoholic in his 60s with over 30 years of sobriety, as consisting of both a “mental obsession and physical compulsion I have to protect myself against.”\(^{68}\) As Mike described it, he couldn’t keep away from drinking or using drugs because he was obsessed with them, and whenever he was close to them he felt compelled to consume them. “The only thing that worked to lift that obsession,” Mike said, “was coming to believe in God and working the spiritual program of AA.”\(^{69}\)

**Conclusion**

The purpose of this chapter was to set out working definitions of spirituality, mental illness, and addiction for this thesis. The definition of spirituality I chose to use is that of the Veterans Affairs (VA) hospitals of the United States, which emphasizes the search for “meaning and purpose in life,” which can be either general or sought through specific practice of “philosophy, religion, or way of living.”\(^{70}\) The term “mental illness,” as used in this thesis to refers to two common and relatively

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\(^{67}\) *Alcoholics Anonymous*, xxviii- xxix.

\(^{68}\) Mike G. Interview by author, 23 July 2012, New Haven.

\(^{69}\) Ibid.

\(^{70}\) Department of Veterans Affairs, “Spiritual and Pastoral Care Procedures,” 2.
less controversial diagnoses, major depressive disorder and bipolar disorder, in adults sampled from DBSA support groups. The defining characteristics of mental illness, according to a NAMI definition I use, are disruptions of “a person’s thinking, feeling, mood, ability to relate to others and daily functioning.” Finally, addiction is defined as a chronic condition with three components: physical, mental, and spiritual. The third component is what 12-step programs such as AA address, encouraging members to believe in a Higher Power or something greater than themselves to finally break free from their addiction.

A final point I would like to address is the issue of equating mental illness and addiction as two psychological conditions that can improve and benefit from the practice of spirituality in a patient’s life. Rev. Kathryn Greene-McCreight, a minister from Yale Divinity School and author of the book *Darkness is My Only Companion* about her reconciliation of Bipolar disorder and her Christian faith, said in an interview that, in her opinion, mental illness and addiction were not equivalent conditions, the former being helped less by spirituality than the latter. While it may be true that spirituality is more commonly used as a primary treatment for addiction than for mental illness, both conditions are chronic and lifelong and both include significant mood and attitude changes over time, often that challenge the patient’s spiritual foundation. Even if mental illness requires additional treatments than just spirituality alone, it was a consensus amongst the mentally ill patients interviewed for

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71 “What is mental illness,” NAMI.
this thesis that their overall wellness is usually proportional to how spiritual they are as well as how compliant they are with other forms of therapy.
Chapter 2: History of Spirituality in Health Care Treatment

Spirituality is a topic on the rise in health care. For many years, the reigning view toward spirituality within the medical community was either negative, as a result of the influence Freud and his followers had on the field, or apathetic, in the case of doctors who favored more testable and mainstream treatments. In the past four decades, however, the medical community has started to pay attention to studies that indicate that investments in spirituality may have positive effects on health. This chapter will examine the effect spirituality can have on health in general, and examine the connections that can be made to mental health.

The Early Years

One of the pioneers in scientifically studying spirituality was Dr. Herbert Benson, a Wesleyan graduate and Harvard-trained cardiologist. In Dr. Benson’s previously mentioned first book, The Relaxation Response, published in 1975, he wrote that he first became interested in the mind/body connection after seeing so many patients come to him with hypertension (high blood pressure) and the typical response by the medical community was to prescribe medication. Many of the patients he saw experienced negative side effects on the blood pressure medications, which led Dr. Benson to wonder if there were not other, non-medical, means of dealing with the problem. He was interested in the mind/body connection and meditation as potential solutions, but this was considered “scientific heresy” at the time.\(^73\)

\(^{73}\) Benson, Relaxation Response, x.
Despite the difficulty of pursuing such ideas at the time, Dr. Benson did not give up on his fascination with the subject. He made numerous visits to India, where he witnessed Tibetan monks draped in cold, wet towels not only not develop hypothermia but also make the towels dry through meditating and producing hot steam.\(^74\) If the human mind and body were capable of such incredible feats, Dr. Benson was determined to find out if health benefits could be gained through focusing on the connection between the two.

Quietly but diligently, Dr. Benson set up and carried out studies on various types of meditation, including Transcendental Meditation, Zen and yoga, and his own simple form called the “relaxation response.” He found that practicing these forms of meditation as few as 30 minutes per day yielded tremendous health benefits, including decreased oxygen consumption, respiratory rate, heart rate, and blood pressure.\(^75\) Further, he found that these benefits were only sustained over time in those subjects who continued to practice the meditation daily; as soon as an individual who had been meditating stopped, the reverse effect occurred and the health levels measured returned to what they were pre-meditation or relaxation response.\(^76\)

**Harold Koenig and the Deeper Exploration of Spirituality in Medicine**

Dr. Harold Koenig, now director of the Duke University Center for Spirituality, Theology and Health is another key figure in the advancement of the scientific study of spirituality and faith. In his 1999 book, *The Healing Power of*
Faith, Dr. Koenig voiced very similar concerns to the ones Dr. Benson did when he first began exploring the subject: “Launching such a disciplined research study into the health benefits of religious faith in the mid-1980s was scary. I was a young resident and sure didn’t want to get branded as an ‘unscientific’ religious zealot.”

Nevertheless, Dr. Koenig continued with his work, initially examining elderly patients and then broadening to other demographics, until the medical field began to take note.

Prior to Dr. Koenig’s work, the field of spirituality and health was not particularly systematized or able to paint a whole picture of the benefits of spirituality, religion, and faith on one’s health. Since beginning his work in the mid-1980s, Dr. Koenig and his colleagues have found the following health benefits from religion:

- People who regularly attend church, pray individually, and read the Bible have significantly lower diastolic blood pressure than the less religious. Those with the lowest blood pressure both attend church and pray or study the Bible often.
- People who attend church regularly are hospitalized much less often than people who never or rarely participate in religious services.
- People with strong religious faith are less likely to suffer depression from stressful life events, and if they do, they are more likely to recover from depression than those who are less religious.
- The deeper a person’s religious faith, the less likely he or she is to be crippled by depression during and after hospitalization for physical illness.
- Religious people have healthier lifestyles. They tend to avoid alcohol and drug abuse, risky sexual behavior, and other unhealthy habits.
- Elderly people with a deep personal (“intrinsic”) religious faith have a stronger sense of well-being and life satisfaction than their less religious peers. This may be due in part to the stable marriages and strong families religious people tend to build.
- People with strong faith who suffer from physical illness have significantly better outcomes than less religious people.
- People who attend religious services regularly have stronger immune systems than their less religious counterparts…

• Religious people live longer. A growing body of research shows that religious people are both physically healthier into later life and live longer than their nonreligious counterparts…

While it may seem that Dr. Koenig’s general findings are only tangentially related to a thesis exploring spirituality and mental health—in *The Healing Power of Faith* he only studied individuals who considered themselves religious and attended church rather than spirituality more broadly, and he only examined situational depression, not prolonged mental illness—they are still an important part of understanding the progress that has been made in scientifically studying spirituality.

It was in Dr. Koenig’s definition of “faith” that I saw many parallels with responses I received in interviews with patients. Dr. Koenig’s definition, whether applied within or outside of an organized religion, was consistent with the definition of spirituality used in this thesis and provided by many of the patients interviewed:

The nature of “Faith”…is described by many of my patients as the confident belief in a supreme being, which most call God…They trust in God to fill the gap between what they could endure and what is actually required of them. They do not struggle alone, but rather see God as their active partner in the continuous struggle to achieve peace and balance in their lives.

This idea of a “supreme being,” “Higher Power,” as the AA program and many interviewees called it, or God, is a quintessentially spiritual concept, as it helps individuals find meaning and purpose, especially in suffering. The idea of not suffering alone is also an important one echoed by patients I interviewed, as one of the worst aspects of mental illness and addiction is isolation, which feeds on itself.

James S. described his experience of finding faith as a gradual one, though the terms he used very much aligned with Dr. Koenig’s definition:

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78 Ibid., 24.
I didn’t know what I was praying to at first—I just called it God—but it worked. The moment I was willing to believe and try it, that’s what kept me sober. My own Higher Power has changed, and now I have beliefs about what I’m praying to. You don’t have to know what you’re praying to but you have to believe in something greater than yourself. For me, that’s the spirit of the universe and a greater intelligence.\textsuperscript{79}

It is important to note, however, that James S. does not consider himself a religious person—ascribing to a particular religion and attending regular services and gatherings of that religion, as Koenig establishes for the purposes of conducting his studies. Nevertheless, the faith that he practices fits the definition of the faith practiced by the religious individuals Koenig studied. This is a salient point because it demonstrates that both the communal religious experience \textit{and} the personal spiritual experience of God benefit health, rather than one more than the other. However, Dr. Koenig raises a valid point that without establishing some measurable religious parameters, faith really cannot be studied. Because spirituality varies greatly in individual definition, belief, and practice, it cannot be researched nearly as well, only investigated on a person-by-person basis, as I did for this thesis.

While it is true that many religious individuals tend to have faith and be spiritual, that is not necessarily a guarantee of increased benefits to health. James S. provided the example of people who say they believe in Jesus as their God but are still angry and spiteful toward others. “Then there are people,” James said, “who see Jesus’s teachings and live them in their lives and are content. That’s incorporating both spirituality and religion.”\textsuperscript{80} James makes the claim that it is active investment in

\textsuperscript{79} James S. Interview by author, 28 December 2012, Skillman.
\textsuperscript{80} Ibid.
religious or meaning-making practices that matters more to practicing spirituality and having faith than being religious in name only while treating others poorly.

Another patient, Caroline H., spoke of how she grew up in a Jewish, but non-spiritual home: “I grew up in a Jewish home, but was my family spiritual? No, they just practiced some traditions. I didn’t become spiritual until I began recovery and started working the [twelve] steps [of AA].”

The testimony of James S. and Caroline H. demonstrates the need to be discerning when considering the benefits of religion and spirituality on health, because it seems that the religious individuals who experience better health that Dr. Koenig studied also tended to be spiritual. Likewise, even though the spiritual beliefs and practices of individuals outside of organized religions cannot be as easily researched, if the individuals regularly practice prayer and meditation, in the form of the relaxation response or another method, they will likely experience similar benefits to the individuals Dr. Koenig studied. Indeed, many of the patients interviewed for this thesis described experiencing the benefits Dr. Koenig detailed: an alleviation of the severity of their depression, cravings, and other symptoms of their illnesses, healthier lifestyles, and a strong sense of well-being even in difficult times. The other health benefits Dr. Koenig detailed in the bulleted list above would specifically need to be tested for using medical methods, some of which is being done in the labs of Yale Psychiatrist Judson Brewer.

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The Effect of Meditation on the Brain

Dr. Judson Brewer of Yale University is one of the present-day experts in the field of mind/body connection and biofeedback. He and his lab have conducted numerous studies and published many positive findings about the connection between meditation, a process through which one detaches from ego and self, and mental health. I spoke with Dr. Brewer, who provided me numerous academic research articles he and colleagues had written, all on the topic of meditation. While the papers themselves were fairly technical, Dr. Brewer explained the main findings very clearly:

I think that from the PNAS paper⁸² we learned that there might be something common to all of these practices [concentration, loving-kindness, and choiceless awareness]. There may be some underlying core element in those three meditations. There were some small differences, but we were particularly struck by there being a particular brain region deactivated during all three meditations that has some “biological plausibility,” meaning it makes sense. This was the posterior cingulate, which is thought to be involved with self-referential processing. This is part of the default mode network. What are we constantly doing? We’re thinking of ourselves…I think in this sense if there is a common underlying mechanism to all spiritual traditions, it may lie in the letting go of self, letting go of ego. You see it in Christianity; you see it in all the schools of Buddhism—that the self is the problem.⁸³

While Dr. Brewer’s work does have implications for the practice of spirituality in the form of meditation, he didn’t want to provide an exact definition of spirituality because he says, “it would just give people a place to fight and argue, and I don’t

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⁸³ Dr. Judson Brewer. Interview by author, 16 July 2012, New Haven.
think that’s helpful.”84 He did, however, say that he thought a working definition could be “someone letting go of self, unifying with what they conceive of God.”85

Dr. Benson agrees with Dr. Brewer in the sense that it’s not the religion that matters most for the practice of prayer and meditation, but the prayer and meditation itself. In a 2004 feature article on WebMD, numerous doctors studying the effects of prayer on health were interviewed, Dr. Benson among them.86 Dr. Benson said it was the act of repetition of sounds or words in which the power of prayer was found, and that each religion had its own way of achieving that result: “For Buddhists, prayer is meditation. For Catholics, it’s the rosary. For Jews, it’s called dovening. For Protestants, it’s centering prayer. Every single religion has its own way of doing it.”87

More Contemporary Progress: Classes, Assessments, and Clergy and Patients Speaking Out

The list of influential doctors and researchers examining the field of spirituality and mental health is far longer than simply those already mentioned in the chapter, and whole other books have been and are being written about it. Some other key figures in the field I wish to briefly discuss here include: Dr. Christina Puchalski at the George Washington Institute for Spirituality in Health (GWish); Dr. Michael Norko and Rev. Mary Dansinghani at Yale University; Dr. Larry Culliford at the Brighton and Sussex Medical School; Dr. Daniel Sulmasy and Sister Nancy Kehoe;

84 Ibid.
85 Ibid.
87 Ibid.
and patients writing about their own experiences, authors and Revs. Kathryn Greene McCreight and Katie Norris, and Kimme Carlos. Even this is a far from exhaustive list, but it does paint a more complete portrait of influential figures in the field.

Dr. Christina Puchalski is the founder and director of The George Washington Institute for Spirituality and Health (GWish), a prolific author on the subject, and has collaborated with Dr. Koenig at conferences before. She recently edited the *Oxford Textbook of Spirituality and Healthcare*. On publishing this textbook, Dr. Puchalski said:

> I have wanted to publish a textbook in spirituality and health for many years, but we needed to build the scholarly and clinical work as a basis for this emerging field. There is now a great demand for such a body of work. The textbook is a reflection of how far we’ve come in developing a scholarly field in spirituality in health.  

Dr. Puchalski’s textbook, as well as a course taught at Yale University School of Medicine by Dr. Michael Norko and Mary Dansinghani, is quite recent. When I began researching for this thesis in June 2012, the textbook had not yet been published. Dr. Norko provided me the syllabus and PowerPoint presentations to the course he’s been teaching to Yale medical students the past two years with Rev. Mary Dansinghani, a clinical pastor.

Dr. Larry Culliford, a British psychiatrist, has been a leader in advocating for spirituality to be examined in health care for much of his medical career, and was a co-founder of the Royal College of Psychiatrists ‘Spirituality and Psychiatry’ Special

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Interest Group.\textsuperscript{89} In his book, \textit{Love, Healing and Happiness}, he writes a chapter on spirituality and health, and eloquently states what he believes the goal of spirituality in health care to be:

> While relief of symptoms and, if possible, their eradication are important in health care, the primary aim from the spiritual perspective is towards the healing of the whole person. This often means that the person experiences adversity instead of avoiding it, in the process developing maturity through enduring hardship and transcending suffering.\textsuperscript{90}

This theme of developing maturity through experiencing adversity rather than avoiding it is one that will reappear in future chapters when patients discuss their personal experiences of struggling with, but ultimately maintaining, their spirituality.

Representing a different perspective than those of typical medical researchers are Dr. Daniel Sulmasy, also a Franciscan friar, and sister Nancy Kehoe, a Catholic nun and clinical psychologist. In his book \textit{The Healer’s Calling}, Dr. Sulmasy distinguishes himself from those who simply study spirituality in health care, writing “this is not a book \textit{about} spirituality in health care. It is a book \textit{of} spirituality in health care.”\textsuperscript{91} He qualifies that statement by saying that even though he is qualified to study spirituality in an abstract way, instead he tries to actively practice it in his role as a doctor caring for patients. Similarly, in her recent book \textit{Wrestling with Our Inner Angels}, sister Nancy Kehoe writes of how, in the 1980s, she questioned the omission of spirituality mental health care:

> Since I didn’t want to deal with potentially negative projections, only a few members of the psychiatry department knew I was a member of a religious

\textsuperscript{90} Ibid., 20.
\textsuperscript{91} Daniel P. Sulmasy, \textit{The Healer’s Calling: A Spirituality for Physicians and Other Health Care Professionals} (New York, NY: Paulist Press, 1997), 3.
order. I developed my clinical skills while quietly observing the fact that no one ever mentioned religion in relation to a client—for me, an intriguing omission. As I began to feel more clinically secure, I questioned the omission.  

Sister Kehoe went on to become a leading advocate in the field of spirituality and mental health, creating spiritual support groups that still exist at a day treatment center in Massachusetts.  

Finally, spirituality as a topic in mental health care is gaining advocacy not only from some in the medical establishment, as well as medical professionals with religious backgrounds, but also directly from patients themselves. Three individuals I interviewed for this thesis, Revs. Kathryn Greene-McCreight and Katie Norris and Kimme Carlos, have all written about their experiences with mental illness. Rev. Greene-McCreight, an Episcopalian chaplain in New Haven, wrote *Darkness Is My Only Companion: A Christian Response to Mental Illness*, in which she details her struggle to reconcile her faith with repeated hospitalizations for Bipolar Disorder.  

Rev. Katie Norris, a Unitarian minister from Ohio with Bipolar Disorder, maintains a blog, www.bipolarspirit.com, on which she writes about her illness and spirituality.  

And Kimme Carlos, a Christian mental illness advocate from Trenton, NJ, wrote a memoir *The Window of Grace: Living in Recovery Through Christian Faith*.  

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93 Ibid., xxiii.  
These are three voices of a growing movement in which patients themselves speak out and share their experiences with spirituality and mental illness. On January 18th, 2013, the National Alliance on Mental Illness (NAMI) posed the question “Does religion and spirituality help you maintain your mental health?” on its Facebook page, which received 384 responses, mostly from patients. A vast majority of the responses were positive, some negative and some indifferent, but the most important part about the post was that it generated discussion. The more individuals suffering from mental illness and addiction feel they can share their experiences with other, the more progress can be made in understand the effects of different types of spiritual practices.

A Final Note on Spirituality and Healing

The title of this thesis indicates that, in addition to a “coping mechanism,” spirituality can also be a “healing tool” for mental illness and addiction. The coping mechanism idea will be elaborated on in chapter four, which examines how patients maintain faith facing the chronic struggles of mental illness and addiction. Spirituality as a healing tool for these conditions, however, should also be qualified: unlike 90% of sick people, for whom empirical evidence indicates that they will recover regardless of treatment, mental illness and addiction are not curable conditions. At best, prayer and meditation can bring some improvement in mentally ill and addicted patients’ recoveries (i.e. alleviating some of the symptoms of their illnesses), while at worse, it can do little to prevent these illnesses from taking their

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courses, whether that’s a relapse for an addict or a hospitalization for a depressed or bipolar patient. With that said, I next turn to examining the ways in which spirituality manifests in patients’ lives and the effect it has on their recoveries.
Chapter 3: Types and Effects of Spirituality in Mental Illness and Addiction Recovery

Up to this point in the thesis, religion and spirituality have only been discussed in theoretical terms, not in terms of actual practice. Each of the 15 patients I interviewed had different experiences with spirituality and a different path to getting to where they were in their spiritual journey. In this chapter I will describe the spiritual experiences of the patients to give a sense of how varied they were. I will then go on to show that, despite these differences in belief or practice, the effects of spirituality on their lives were very similar.

Despite a great degree of variation in the types of spirituality practiced by the patients I interviewed, the effects of that spirituality on their lives had many similarities. The differences in definition and practice of spirituality were likely due to the patients interviewed being chosen from two non-denominational support groups with no particular religious affiliation, Alcoholics Anonymous (AA) and Depression Bipolar Support Alliance (DBSA). Also, we live in a country, and a specific area of the country, the northeast, where religious diversity is well tolerated. This is reflected in the heterogeneity of the religious and spiritual beliefs sampled for this project. The similar effects of spirituality, however, which will be elaborated on throughout the rest of the chapter, spoke to an underlying search for wholeness in one’s life.

It is important to note that spirituality was by no means a magic bullet in resolving all of the mental turmoil the patients experienced. Rather, in the difficult struggle to find some form of centeredness, calmness, and peace in one’s life, spirituality was an important aspect of patients’ recovery processes. Because the
perspectives were so varied, in an effort to give them some type of order, for the purposes of this chapter, I have organized them into the following categories: Western Perspectives; Eastern and Alternative Perspectives; and Dual-Diagnosis Perspectives.

*Western Religious Perspectives*

Four male patients interviewed for the thesis considered themselves Catholic, though none of them were from the same church. Three were raised Catholic and one converted to Catholicism after getting sober later in life. Adam D., a man in his sixties with bipolar disorder, said that, despite suffering from his illness since his sophomore year of college, he’s “always had a love for the Catholic faith.” Adam described his religion—Catholicism—and his spirituality—his personal relationship with God—as being inseparable from and reinforcing one another. For much of his life, Adam said he would question God for afflicting him with bipolar disorder, asking, “Why me?” As he got older, however, he came to believe that “God has given me this cross to carry. I’m grateful to acknowledge his love and acknowledge the fact that he’s given me the privilege to share in [Jesus’s] suffering.” However, being able to reconcile his illness with his faith did not mean it was easy for him to continue religious observance; Adam said that, at times, depression is so debilitating that he can’t make it to church or even string together his thoughts to pray. Other patients echoed this experience as well.

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99 Adam D. Interview by author, 10 July 2012, New Haven.
100 Ibid.
101 Ibid.
102 Ibid.
Alan B., a high school teacher in his forties with bipolar disorder, came from a very religious family in which two of his five siblings became ordained Catholic priests. Alan described his struggles with bipolar as interfering with his ability to worship and practice faith. For him, it was a sort of negative reinforcing cycle: he was less observant of his faith because of his illness, and he felt more depressed because he was less observant of his faith. At one point, Alan felt so overwhelmed and hopeless that he went to church on Sunday and “was just staring at the cross, [not] thinking about anything else, saying ‘C’mon, help me out.’”

A few days later, he attempted suicide. It wasn’t until he reached this point of complete desperation, lying on his hospital bed, that he realized that “there’s still a lot more to do in the world in my life.” Coming to that realization in the hospital allowed Alan to rebuild and reincorporate religious practice into his life. Now he attends church weekly—not just when he is in emotional pain like before—prays before meals, and at times during the day thinks about and converses with God.

Brandon A., a religious scholar trained at Yale Divinity School who was diagnosed with bipolar disorder in his mid-twenties, echoed this idea of God sharing in peoples’ suffering: “We had a God who suffered. When there’s darkness and gloom, you can realize that God [is sharing] in our suffering.” At this stage in his life, Brandon said larger Catholic services no longer appealed to him and that he preferred the quiet, low-key church he and his family attended on Sundays.

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103 Alan B. Interview by author, 24 July 2012, New Haven.
104 Ibid.
105 Ibid.
106 Brandon A. Interview by author, 17 January 2013, Skillman.
107 Ibid.
him, church was no longer the staple of his spiritual practice—admitting that he would attend when he could, if family commitments didn’t interfere, which they sometimes did—but a supplement to other practices in his life, such as nature walks and prayer.\footnote{Ibid.}

For Mike G., it wasn’t until he became sober later in life that he considered joining a church community and converted to Roman Catholicism. As he put it, “the church was very friendly to AA, so I got a lot of real world skills from church. And of course AA gave me some direction to apply the skills, gave me the direction I needed.”\footnote{Mike G. Interview by author, 23 July 2012, New Haven.} In other words, without learning the tools he needed to stay sober in AA, learning the tools for helping others and leading a religious life would likely not have made a difference in his life because he would still be drinking.

In these four experiences, I observed while all four patients identified as Catholic, there was a tremendous variation in individual practice and perspective. There was even more variation in the next four patients, who also came from Western religious perspectives.

Caroline H., a peer-to-peer mental health program facilitator who suffers from depression and alcoholism, was the clearest example I saw of how religion could provide a buffer for someone against both mental illness and addiction. Caroline was raised in a Jewish household that “just practiced some traditions,” but was not spiritual, in her opinion.\footnote{Caroline H. Interview by author, 27 July 2012, New Haven.} It wasn’t until she came to AA in her thirties after 16 years of heavy drinking did she discover what spirituality really was. To her,
spirituality “is having a personal relationship with God,” which is something that for her culminated in being saved and accepting Christ as her savior last year. While Caroline does not recommend that patients stop taking their medications, and acknowledges that medications are very helpful in treatment a lot of the time, at the time of the interview she had been medication-free for 6 months (under the supervision of her psychiatrist) and believed “that because of [being saved], that’s how I’m medication free—doing what I’m doing and being forgiven.”

Kimme Carlos, author of *The Window of Grace* and mental health advocate who suffers from addiction and anxiety, had a similar experience to Caroline, except she has been Christian her whole life. In her late 30s when she finally entered into recovery, she found herself struggling with alcohol and nicotine addictions, food, and relationships. She had been in the Christian church since she was a child but didn’t find relief from her mental conditions until she returned and rededicated herself to God as an adult. She said she stumbled upon a scripture, Corinthians II 5:17, which she paraphrased, “Therefore if any man be in Christ, he is a new creation. Old things are past away and things become new.” It was this idea of being able to begin a new, healthy relationship with God on the path to recovery that resonated with her.

Olivia R. and Kate O. were both Unitarian Universalists, Olivia being raised in the faith and Kate joining a church after entering into recovery. Olivia said it was ironic that she had such a difficult time coming to believe in a Higher Power once she

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111 Ibid.
113 Kimme Carlos. Interview by author, 20 January 2013, Trenton.
114 Ibid.
finally decided to quit drinking: “For 13 years I went to a church that taught love and service…I couldn’t understand that once I started using [alcohol and drugs].”¹¹⁵ Kate found Unitarianism to be a welcoming faith that didn’t judge her for her past actions and accepted her struggles with mental illness and addiction.¹¹⁶ At one of the recent church services Kate was at, the theme was mental illness, which she really related to: “I think it’s important for people to tell their stories so people realize they’re not alone.”¹¹⁷ These elements of community understanding and support were important parts of spirituality for Kate.

*Eastern and Alternative Perspectives*

Two of the patients interviewed were Buddhists who did not believe in a God. Rather, they saw the goal of spirituality to be detaching from one’s ego in order to experience less pain. Phil W., the former neurologist I met in Florida at the Came to Believe meeting mentioned in the preface, described how he reconciled Buddhism’s detachment from self with the Higher Power concept of AA in a seemingly traditional Buddhist way while he was in prison for four years due to unfortunate complications from his drug using days:

I used to say that [spirituality] was anything along the lines of everything that is beyond my ego, or things that are mine. Everything beyond that. For me, my Higher Power wasn’t actually higher or lower, but was Greater than me. [In recovery] I didn’t focus on what it was, but rather what it wasn’t, which was not me. I used to say, ‘I don’t even know if God is spiritual’—I just know that spirituality is not me. The point I’m making is that if I can get outside of me, then maybe I’ll find out what’s going on."¹¹⁸

¹¹⁵ Olivia R. Interview by author, 11 July 2012, New Haven.
¹¹⁶ Kate O. Interview by author, 5 November 2012, Middletown.
¹¹⁷ Ibid.
¹¹⁸ Phil W. Interview by author, 18 January 2013, Skillman.
The other self-identified Buddhist, Charles K., considered himself to be a borrower from most major traditions, but someone who ultimately found Buddhist meditation more effective than praying to God. Ever since getting sober in 1996, Charles had been on a spiritual journey, constantly trying new spiritual belief systems:

I remember reading [William James’s] Varieties of Religious Experience… I used AA as my Higher Power, I read the Koran and tried that because I had some Muslim friends… Later on I tried meditating and I read some Buddhist literature and that resonated with me.119

Though both Buddhists came to find their centering spiritual practice of meditation and “Higher Power” of detachment from ego in different ways, the end result was similar in that they both were able to remain sober and gain clarity in the process.

The agnostic I interviewed, Chris M., was a college science professor who used to drink alcohol to deal with his anxiety. Still teaching, and almost nine years sober, Chris explained that his spiritual journey was a gradual one, developed through experience in recovery. He was ultimately able to reconcile the fact that did not believe in “any god that manifests as human,” with the spiritual practices that he did develop. For Chris, spirituality is:

An appreciation of how I am woven into life. How powers greater than myself can be used to promote personal growth. These powers do not come from a conventional “god” up in the sky, but from everyone and everything around me.

Very different from the others, Marie C. was a 28-year-old woman who had had nothing but unpleasant experiences with psychiatrists and psychiatric medications, so she turned to meditation as a healing spiritual practice. She viewed her spirituality as

119 Charles K. Interview by author, 18 January 2013, Skillman.
something that could emerge only after she had stopped the cycle of being over-
medicated and experiencing memory loss and other side effects:

I don’t know if [my spirituality] developed spontaneously out of necessity due
to how traumatic it was to break the cycle of the medications or whether the
medications had just covered up my spirituality all along.\footnote{Marie C. Interview by author, 20 November 2012, Middletown.}

At the time of the interview, Marie had been medication-free for over a year and half,
and said it was a very difficult experience because she still experienced depression
and mood swings much of the time. To her, however, the benefits of being off of
medications outweighed the costs of being able to feel her emotions, however painful
they may be. As far as spiritual practices went, Marie was similar to many other
patients; she would meditate, do yoga, and read spiritual books. When asked about
the role of balancing spirituality with other treatments in her life, Marie responded, “I
think my spirituality is as important as my nutrition and exercise and psychotherapy.”

\textit{Dual-Diagnosis Perspectives}

It’s difficult to deal with either a mental illness or addiction, but for those who
have both, commonly described by the term dual-diagnosis, spirituality is by no
means a panacea.

James S., a dual-diagnosis 23-year-old, offered an interesting perspective on
how spirituality affects his recovery from both bipolar disorder and alcoholism.
While belief in a Higher Power does not cure one of addiction, it does alleviate the
worst symptom of craving. With mental illness, on the other hand, such removal of
the problem is rarely seen. As James put it, “spirituality can only make mental illness
a little less bad…it’s tricky because it doesn’t completely go away.”

He added, however, that because of his regular spiritual practices of prayer and meditation, he’s “not depressed very much,” and that “things that would normally make me angry I avoid because it makes me more peaceful.”

Another dual-diagnosis patient in his forties, Jeff P., took a different view of spirituality as something that wasn’t a major part of his treatment but helped him to experience more joy in his life. For Jeff, spirituality is something that contributes to overall wellness but cannot prevent episodes of his mental illness from occurring:

I understand the distinction between a treatment program and a spiritual program…Treatments [include] medications, talk therapy, hospitalizations, and electroconvulsive therapy (ECT). I’ve been in a fairly solid spiritual place for years now, but it doesn’t cure my depression. For three years now, I’ve been hospitalized in February, partly a seasonal thing, partly let down after the excitement after [the holidays].

This idea that spirituality does not help as much with overcoming depression as with overcoming addiction was one that Brian L., a dual-diagnosis recent college graduate, spoke of as well. Working the spiritual program of AA helped him stay sober for over four years, but, he said, “if you’re dealing with clinical depression, going to meetings really has limited utility.”

Each of these three dual-diagnosis patients conceived of their spirituality in a different way but had similar experiences—spirituality helped alleviate the symptoms of addiction but provided less protection against the fickleness of mental illness episodes. All three patients said they believed in a “Higher Power,” but as the 3rd step…

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121 James S. Interview by author, 28 December 2012, Skillman.  
122 Ibid.  
123 Jeff P. Interview by author, 10 January 2013, Skillman.  
124 Brian L. Interview by author, 1 December 2012, Middletown.
of AA clarifies, the criteria for that Higher Power is “as we understood Him.”\textsuperscript{125} In other words, James’ conception of God as “light and love…We can go toward the light, or cling to the darkness,” is no less spiritually sound as Jeff’s understanding of AA as his “church” and the other people in AA being conduits of God’s will.\textsuperscript{126} Brian, too, had a different conception of a Higher Power. He said he had a moment of clarity when a counselor in a halfway house explained the Higher Power concept to him this way:

> When I came into the program, my Higher Power was alcohol; it was just a bad Higher Power. When I was drinking I never thought that there was a Higher Power I was following and it was alcohol—that thought never entered my mind. That was the first logic-based approach to a Higher Power that worked for me.\textsuperscript{127}

In other words, before entering recovery, alcohol was Brian’s Higher Power. In other words, Brian had no control over alcohol—alcohol had control over him. Only once he realized this could he choose a different Higher Power to believe in to free himself from the grip of alcohol.

In all three cases, even though each patient’s conception of a Higher Power was different, their faith ultimately provided them relief from their addiction, because they shifted control of their lives from alcohol and drugs to their Higher Power.

While Jeff saw spirituality more as a part of one’s life rather than one’s treatment, and James and Brian felt that spirituality had limits in its effectiveness of helping with mental illness recovery, all three men nonetheless found it positively impacted their health and lives as a whole, and was particularly helpful with their addiction.

\textsuperscript{125} Alcoholics Anonymous, 59.
\textsuperscript{126} James S. Interview by author, 28 December 2012, Skillman.
\textsuperscript{127} Jeff P. Interview by author, 10 January 2013, Skillman.
\textsuperscript{127} Brian L. Interview by author, 1 December 2012, Middletown.
As I progressed through my interviews with patients, regardless of how different their spiritual background or practices were, I began to see similarities in their experiences. While some patients may have believed in God, others in various conceptions of their own Higher Powers, and still others in the idea of detaching from self as the ultimate goal of spirituality, the end results were similar: alleviation of addiction, of some, though not all, symptoms of mental illness, and an overall positive sense of wellbeing. In the next section of this chapter, I further examine and characterize the similar effects of spirituality on the patients I interviewed.

**Similar Effects of Spirituality**

In examining the interview transcripts of the 15 patients, it became apparent that, despite vastly differing spiritual beliefs and practices, many of the effects of spirituality were similar. These similarities were beneficial, and were experienced by a majority of the patients: feeling better mentally; accepting one’s mental illness or addiction; experiencing community support; and living a more balanced lifestyle. It should be noted that from a medical-scientific perspective, the underlying physiological and neurological changes associated with spiritual practices such as prayer and meditation are beginning to be better understood as more research is conducted to study them. Since this interview project was a qualitative study rather than a quantitative one, similar behaviors and lifestyle choices were of greater concern than the underlying neurological processes.

*Mental wellness*

By far the most common response to the question “What has been the effect of spirituality on the symptoms of your mental illness/addiction?” was, in different
phrasings, that spirituality made patients feel better mentally. This common effect of “mental wellness,” as I’ve termed the alleviation or absence of symptoms, could be seen arising from a variety of spiritual practices that the patients had.

For James S., meditation helped alleviate some of his depression because, he said, “I’m more at ease when and after I meditate.” For Jeff P., a similar effect was experienced. Jeff described himself as feeling “more at peace, calmer.” Caroline H. described the effects of spirituality as both improved physical health and heightened mental awareness: “I’m healthier physically, I feel my focus and concentration is sharp, my intuitiveness is heightened.” Listening to Marie C.’s response to the question, “I have felt calmer, happier, more able to accept difficult situations and accept others,” I was struck that, despite coming from different spiritual backgrounds, she and the others were affected in similar ways.

For some patients, their mental wellness was directly contingent upon their spiritual condition. For Adam D., Brandon A. and author Kimme Carlos, during times when they were most involved with their chosen spiritual practices is when they were most healthy. Adam D. said that for him, “there was a correlation between how active I was in faith and the freedom from depression that I was experiencing.”

One of the most difficult aspects of depression, described by Alan B. earlier in the chapter, is the negative cycle it creates of inhibiting one’s ability to successfully carry out one’s spiritual practices. Brandon A. saw a parallel between his spiritual health

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128 James S. Interview by author, 28 December 2012, Skillman.
129 Jeff P. Interview by author, 10 January 2013, Skillman.
131 Marie C. Interview by author, 20 November 2012, Middletown.
132 Adam D. Interview by author, 10 July 2012, New Haven.
and mental health, as well: “[Spirituality is] also part of my mental health care, because I’m trying to put myself in a good space through my relationship with God, and being put in a good space [with God] is also being in a good mental space.”

Finally, Kimme Carlos spoke of the process of her faith fortifying her mental wellness over time:

> The stronger my faith grew, the more my symptoms began to subside... Where I would instantly go for a drink if I were anxious, now instead of drinking I can turn to my faith. I can read my favorite scriptures and pray with a lot more confidence and courage. And again I turn to my support network.

None of the patients interviewed described any negative effects that spirituality had on their mental conditions, but that was likely due to the small sample size. Some research in the field addresses the difficulty in distinguishing religious beliefs from psychotic delusions brought on by a mental disorder. British medical lecturer Simon Dein writes that with psychotic disorders such as bipolar disorder and schizophrenia, “there is frequently an overlap between the mental disorder and religious and spiritual problems – especially in manic episodes, which often contain mystical components.”

The best way to prevent such episodes from occurring or exacerbating, according to Mt. Sinai psychiatrist Dr. Joseph Goldberg and Yale Rev. Ian Oliver, is maintaining close contact with the patient over time. This way, outside observers close to the patient will be able to distinguish between healthy and

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133 Brandon A. Interview by author, 17 January 2013, Skillman.
134 Kimme Carlos. Interview by author, 20 January 2013, Trenton.
unhealthy spiritual practices and intervene if a patient deviates from their set of normal healthy practices or becomes detached from reality.

Acceptance

In addition to mental wellness, another similar effect spirituality had on patients was making it easier to accept and cope with the conditions they had. Adam D. phrased it very powerfully: “My spirituality and my faith don’t eliminate my depression, but they change the way I view my depression.” In other words, depression is a chronic condition that neither spirituality, nor any other therapy, can fully eliminate. However, one does not need to view the depression pessimistically; it is certainly not a good condition, but it is possible to manage it and live a productive life, and spirituality is an important part of that. Kate O., a young Unitarian, said, “Faith gives me hope that this is not just a hopeless situation. I don’t think anyone would ever say ‘I’m happy I’m Bipolar,’ but I am glad I have such a depth of experience.” The first part of Kate’s statement reiterates Adam’s point that spirituality can be maintained even in the midst of depression. The second part of the statement addresses Kate’s acceptance of her illness: although she would prefer not to be bipolar, she has accepted that its challenges have given her valuable life experience.

Alan B. had an interesting perspective on self-determination versus predestination:

I believe in self-determination up to a point. We can chart our own path and be successful if we try. As I’ve gotten older, while that’s still a bit true, I’m starting to see that it’s not just what we want to do that will happen, but

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137 Adam D. Interview by author, 10 July 2012, New Haven.
138 Kate O. Interview by author, 5 November 2012, Middletown.
certain things are out of our hands…There is only so much I can do in life to determine what happens and God has determined things this way.\textsuperscript{139}

Alan was not being pessimistic when he said this, but simply realistic after the many life reevaluations that he had to make due to living with a mental illness. It’s not that Alan gave up fighting the illness he has, but rather he gave up denying that he didn’t have it, which was a spiritual realization for him. This acceptance has helped him and many other patients in their recoveries, as acceptance is a necessary first step in seeking appropriate treatment.

\textit{Community support}

Another widely observed effect of spirituality in the patients interviewed is that it led to them helping other people and also experiencing community support as a result. All of the patients being members of AA, DBSA, or both was a testament to this. Jeff P. joined AA before he became active in a Christian church later on, and said that the “structure and support I get from AA is not all that different from the structure and support that I get from church. I’ve told people in the program, ‘[AA] is my church.’”\textsuperscript{140} Now, Jeff belongs to both AA and a Christian church where he attends bible study group, church services, and frequently is asked to deliver sermons. The community support and ability to connect with others that Jeff found as a result of pursuing spirituality has been invaluable to him in his recovery.

Caroline H., who works in the mental health field, saw her spirituality as a way of putting her conditions in perspective and helping other people by sharing what she’s been through: “[Spirituality has] helped me become more compassionate toward

\textsuperscript{139} Alan B. Interview by author, 24 July 2012, New Haven.
\textsuperscript{140} Jeff P. Interview by author, 10 January 2013, Skillman.
other people. And I do consider that spirituality. I see the turmoil that I’ve gone through in my life as a means of helping other people.”

Today, she shares her experience with patients, psychiatrists and psychotherapists who may have patients who can relate to it, and people in the outside world she thinks may benefit from it. She does this to help people rather than to gain recognition from others: she says she only discloses the fact that she’s in recovery when it is relevant to someone’s struggle, and asks that the other health professionals change her name when telling her story to patients to protect anonymity.

Both Mike G. and Chris M. said that helping other people, and especially other alcoholics, is a crucial part of their spiritual programs. Mike said that the most helpful thing he can do when “things get bad,” i.e. he begins ruminating, feeling sorry for himself, craving a drink, or any other negative emotions, is to go work with another alcoholic. More broadly, though, it could be helping someone from his Roman Catholic Church, or just a random passerby. By helping another person, Mike is, “getting outside of myself and doing something positive, whether it’s cleaning the house [helping his wife], doing favors [helping family, friends and others], or calling someone in AA [checking in on another alcoholic].” In addition to meditation, helping others in a non-selfish way is a very important part of Chris’s program as well. Chris tries to “help others in a manner not motivated by self reasons (feeling

142 Ibid.
143 Mike G. Interview by author, 23 July 2012, New Haven.
144 Ibid.
good about myself for doing it),” and says that the effect has been very positive.\textsuperscript{145}

“Without [spirituality], there can be no growth for me.”\textsuperscript{146}

\textit{Balanced and Holistic Routines}

The fourth similar effect of spirituality on patients was that it helped create a balanced and holistic routine for them, and, in turn, that routine helped strengthen their spirituality. Balanced and holistic care mean similar, but slightly different, things. Balanced means that no one therapy or form of healing is used at the exclusion of others, for instance, one cannot expect medications to be the source of recovery if psychotherapy, prayer and meditation, interaction with others, nutrition, and exercise are ignored. Holistic means treatment of the whole person rather than just symptoms of their condition, which means paying attention to beliefs and lifestyle.

Caroline H. was the patient who spoke the most of holistic care, and she described in depth the effects that many other patients experienced as well:

Part of my success in sobriety is a holistic approach…What I’m talking about with the holistic approach is having an all around wellness plan. It’s not like “I’m going to eat well and I’m going to expect to feel well and spiritual.” For me when I say the holistic approach, it’s: praying and meditating, eating right, exercising, having a strong network of friends, going to AA and church. My spirituality strengthened these things, and these things strengthened my spirituality.\textsuperscript{147}

Caroline also added that part of her holistic treatment plan is doing some activities that are “light,” meaning they don’t focus on the pain piece of mental illness and addiction. For her, that included drawing, listening to music, being outdoors, taking

\textsuperscript{145} Chris M. Interview by author, 18 January 2013, Skillman.
\textsuperscript{146} Ibid.
\textsuperscript{147} Caroline H. Interview by author, 27 July 2012, New Haven.
walks, and going to the beach and being near the water.\textsuperscript{148} Caroline recognized the symbiosis, i.e. the mutually beneficial relationship, between spirituality and other aspects of holistic care. The more she cultivated both, barring unexpected episodes, the healthier she became.

Adam D., Kimme Carlos, and other patients from Western religions said that they saw spirituality and other forms of therapy as not competing. Adam D. said, “I believe that the other forms of therapy [such as medication and psychotherapists] are gifts from God and instruments of God’s grace.”\textsuperscript{149} Kimme Carlos went further and criticized those who say if you pray hard enough you shouldn’t need to take medication: “Nobody would ever tell somebody with a heart condition to stop taking their medication.”\textsuperscript{150}

Mike G. spoke to the effect of good habits building momentum and then leading to the formation of other goods habits:

Sometimes one good habit leads to another. Going to AA and getting the spirituality to stay clean happens first. Then the question is now what do I do? Then things come along to be good to and take care of myself. I go exercise 2-3 times per week, I try to watch my weight and what I eat. Interestingly enough, one of the catchwords we have [in AA] is HALT—Hungry, Angry, Lonely, and Tired—and this combination is to be avoided, as it can lead to a slip.\textsuperscript{151}

The HALT acronym is helpful as it covers four major bases in holistic therapy—nutrition, stable mood, loneliness, and sleep—which if neglected will likely lead to relapse or an episode. Another important point that Mike makes at the beginning is that first one must get “clean.” In the case of an addict that means free from alcohol

\textsuperscript{148} Ibid.
\textsuperscript{149} Adam D. Interview by author, 10 July 2012, New Haven.
\textsuperscript{150} Kimme Carlos. Interview by author, 20 January 2013, Trenton.
\textsuperscript{151} Mike G. Interview by author, 23 July 2012, New Haven.
and other substances; in the case of a mentally ill patient, that means emotionally stable to the point of being able to function in society, which could require hospitalization and medications before that point is reached. The main point is that without some baseline emotional and mental stability, the other aspects of holistic therapy will be very difficult to implement and perhaps even deter someone from going to AA or seeking professional help.

Brandon A. and Chris M. brought up the idea that spirituality and other forms of therapy are not separate, and that spirituality can be integrated into the other forms. For Brandon, it was a matter of not having enough time in his life to always set aside time for formal prayer and meditation. As he put it:

There’s not a lot of time for spirituality in my life. I have four kids, a wife, and am always going to and fro. Exercise, nutrition, and spirituality can fit themselves together. It’s hard to set aside time for just therapeutic spirituality, but in spite of that I still try to weave it into things that go on throughout the day.\(^{152}\)

Chris felt the same way, and when asked about how he balances spirituality and other practices, he said he combined the two: “For me, spirituality can be integrated into other healthy practices, such as psychotherapy, exercise, and nutrition. I meditate most often while exercising—taking long walks, bike riding…”\(^{153}\)

**Conclusion**

This chapter sought to accomplish two things: first, to detail the spiritual experiences of the 15 patients interviewed for this project, noting that each of them had different beliefs and practices; and second, to review what the patients described as the effects of their spiritual practices, and identify the similarities. The Western

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\(^{152}\) Brandon A. Interview by author, 17 January 2013, Skillman.

\(^{153}\) Chris M. Interview by author, 18 January 2013, Skillman.
spiritual backgrounds ranged from Catholic to Unitarian, Baptist to Jewish convert to Christian. The Eastern and Alternative backgrounds ranged from Buddhist to Agnostic to believing that medications and psychiatric diagnoses are harmful.

More similarities than differences were identified when examining the effects of these spiritual beliefs and practices on patients’ recoveries. Four prominent similarities emerged: mental wellness (i.e. the alleviation or absence of symptoms), acceptance of condition, experiencing community support, and developing balanced holistic routines. These four effects of spirituality on recovery from mental illness and addiction observed in the patients interviewed for this thesis suggest an important role of spirituality in mental health. Hopefully, those in the medical and treatment communities will consider spiritual practices more widely as complementary therapeutic modalities in the future. Next, I turn to examining the question of how patients maintain their spiritual beliefs in the hardest times of their recovery, such as relapse or the recurrence of a depressive or manic episode.
Chapter 4: Maintaining Spirituality Facing Chronic Struggle

How patients maintain their spirituality while facing the challenges of their chronic conditions is one of the core questions this thesis seeks to explore. Pre-existing literature on spirituality and mental health largely does not address this question. Apart from memoirs, from which few generalizable conclusions can be drawn, few books have been written about the difficulty of maintaining spiritual belief during the most trying times of one’s struggle with mental illness and addiction. In his 2011 book, *Out of the Darkness: From Turmoil to Transformation*, author Steve Taylor argues that spiritual awakening can occur in some of the most hopeless cases, leading to “permanent heightened awareness…a sense of meaning and purpose, and a permanent inner well-being, free of worry or anxiety.”\(^\text{154}\) While his book examines exceptional cases of individuals experiencing spiritual awakening through turmoil, Taylor acknowledges, “in most cases, psychological turmoil doesn’t have any positive effects.”\(^\text{155}\) This chapter is intended to discuss the difficult reality of mental illness and addiction that remains even after all therapies, including spirituality, have been exhausted, and how patients can maintain their spiritual beliefs in the face of this.

To gain a better understanding of the difficulties patients faced in maintaining their spirituality, I asked two questions: first, “How do you reconcile spirituality and belief in God with your mental conditions and the pain they cause you?” and second, “How have you managed to maintain spiritual belief and faith during the worst of


\(^{155}\) Ibid., viii.
times of your recovery—battling with depression, anxiety, cravings, difficult life circumstances, etc.?” I also asked the clergy I interviewed a related question about the guidance and support they offer to patients who come to them struggling with faith: “What is the best advice you would give to someone, who is either still struggling with their illness or struggling with depression, cravings, and other difficult conditions in recovery, on how to maintain their spirituality or faith?” Both patients and clergy had a wealth of experience grappling with the philosophical and practical aspects of maintaining faith in hard times. This chapter examines their experiences and the lessons that caregivers can draw from them.

The Challenge of Mental Illness and Addiction: How Can Patients Help Themselves When They Feel So Helpless?

Before examining how patients reconcile and maintain their faith while suffering, the unique challenges of recovery from mental illness and addiction should be addressed. Mental illness and addiction are both conditions that make the process of recovery and getting well for patients more difficult, for a number of reasons. First, mental illness and addiction are very easy conditions to deny, as verifiability for them is limited. Medical tests and scans do not exist for mental illness in the same way they do for many physical illnesses. Second, mental illness and addiction are much more stigmatized than other health conditions, so patients have a strong incentive not to accept these diagnoses. Third, the conditions themselves seem to make compliance with various forms of treatment harder than for people with other types of illness. This is not meant to diminish the recovery experiences from other forms of illness or loss, but the same type of treatment resistance does not seem as common. This may be due to the way in which mental illness and addiction profoundly affect a patient’s
perception of reality in a way that physical illnesses often do not. Unlike with other health conditions, mental health conditions make it difficult to do the very things needed in order to get well.

Almost all of the patients interviewed said that they struggled with accepting that they had mental illness or addiction, and subsequently would resist treatment by self-discontinuing their medications, stopping attending 12-step meetings, and isolating from friends, medical professionals and other caregivers. Denial or difficulty accepting may be present in other chronic conditions such as terminal illness, or situational events such as the loss of a loved one, though generally not nearly to the same extent.

In the next section, I will examine through patient interviews how patients deal with these obstacles and maintain their spirituality.

Reconciling Spirituality with Illness

The biggest factor in reconciling belief in God with the pain caused by mental illness and addiction was a patient’s ability to accept the mental conditions they had, and not to blame God or a Higher Power for having them. For some patients, this took the form of viewing their suffering through a Christian religious narrative. Caroline H., Adam D., and author Kimme Carlos all saw their suffering as a way to come closer to God through sharing in Christ’s suffering.\(^{156}\) Describing his experience, Adam D. said, “When I experience pain from my illness, I’m reminded

\(^{156}\) Caroline H. Interview by author, 27 July 2012, New Haven.
Adam D. Interview by author, 10 July 2012, New Haven.
Kimme Carlos. Interview by author, 20 January 2013, Trenton.
that we share in [Christ’s] suffering—some of us are called to share more intensely than others.”

Caroline, also a member of AA, added that each morning she prays, “for God’s direction, asking to carry out his will, not mine.” This is essentially a shortened version of the 3rd Step prayer of AA, which reads:

Many of us said to our Maker, as we understood Him: “God, I offer myself to Thee—to build with me and do with me as Thou wilt. Relieve me of the bondage of self, that I may better do Thy will. Take away my difficulties, that victory over them may bear witness to those I would help of Thy Power, Thy Love, and Thy Way of life. May I do Thy will always!”

This idea of carrying out a Higher Power’s will rather than one’s own will is important to understanding the aim of the AA program to discourage self-reliance in matters of drinking and drug use, but more generally, in life. There are certain things out of one’s control, such as whether one has a mental illness or addiction, and there are certain things in one’s control, such as seeking help for one’s condition, staying sober, and living in as healthy a way as possible. By accepting the things that are out of one’s control, and taking action on the things that one can influence, patients are better able to come to terms with their conditions.

While other patients may not have viewed their suffering through the same Christian lens as Caroline, Adam, and Kimme, the idea of a loving, protecting Higher Power looking over them was one that many other patients shared. For Jeff P., his belief in a Higher Power, which he chose to call God, helped him view his condition of bipolar disorder “not as a deficit, but as something positive.”

157 Adam D. Interview by author, 10 July 2012, New Haven.
158 Alcoholics Anonymous, 63.
159 Jeff P. Interview by author, 10 January 2013, Skillman.
statement by saying that, of course, the symptoms of pain and emotional turmoil that resulted from bipolar disorder were not positive, but that he has come to see God in a unique and powerful way, as a result of his condition: “If I didn’t have the afflictions I have, I wouldn’t be able to see God in the same way, so I ultimately became grateful for even the worst I’ve been given.”

Mike G., a practicing Roman Catholic, took a more pragmatic than religious approach to reconciling the suffering with God:

No matter how bad things are, they can always get worse—you can bear that in mind. Like having a badly sprained ankle, you have to take care of it or it will get worse. Take care of yourself. Respect yourself enough to give yourself the best care possible. For me it’s reading the Bible, praying the rosary, trying to be thoughtful of other people, and inviting their kindness and love to me when I need it.

In other words, rather than challenging God and asking “why me?” questions, Mike prefers to focus on the fact that he has a lot to be grateful for and that things could be a lot worse. Rather than ruminating, being self-critical, feeling sorry for himself, or blaming God, he throws himself into his regular religious and spiritual practices to strengthen his connection with God even during difficult times.

Brandon A., Charles K., and Kate O. all had the perspective that these conditions were their limitations or challenges to deal with, and did not regularly invoke God in their thoughts, except to say that God helps give them strength to endure these conditions. Brandon and Charles both used the term “cross to carry,” to

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160 Ibid.
161 Mike G. Interview by author, 23 July 2012, New Haven.
describe their conditions, bipolar disorder and alcoholism, respectively. \(^{162}\) Brandon elaborated:

> Most people have some debilitation in their life, or their “cross to carry.” [Bipolar disorder] is my cross to carry…I’m in the position I’m in and I have to make the best of it. I don’t believe that putting down religion would make things better—I think it would make them worse. I like to believe that paradise exists, but for now I have to deal with this reality. \(^{163}\)

Kate O. described the same concept but in different words: “people are all dealt different cards.” \(^{164}\) Some people have mental health issues, some people have physical health issues, some people experience a lot of tragedy in their lives, and these are all things that are out of human control. What God or a Higher Power calls each of us to do, she said, is deal with these issues as best we can.

**Maintaining Spirituality in the Face of Suffering**

*When Spirituality Can Be Maintained*

Spirituality is not maintained and nourished in isolation; rather, spirituality in the contemporary U.S. is an intensely interpersonal and interactive thing. It should be noted that all of the patients interviewed were members of support groups for their conditions—either AA, DBSA, or both—and considered that group membership to be a part of their spirituality. Jeff P. went so far as to say that he considered AA to be his church. \(^{165}\) Many other patients interviewed echoed the sentiment that interaction with others, not just solitary meditation and reflection, is crucial to maintaining their spiritual wellbeing. Mental illness and addiction generally cause patients to feel

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\(^{163}\) Ibid.  
\(^{164}\) Kate O. Interview by author, 5 November 2012, Middletown.  
\(^{165}\) Jeff P. Interview by author, 10 January 2013, Skillman.
isolated from others. If the conditions are severe enough, places where people normally interact with others, such as school or work, may not be available to them. Membership in a church or support group was a way that patients could belong to a community and receive support in maintaining their spirituality.

Almost all of the patients acknowledged that how they maintain spirituality facing depression, cravings, or difficult life circumstances is a very difficult question. Brian L. said the best way to maintain faith in tough times is to “look back and see the ways your Higher Power has worked in your life.”166 Brian noted that this could be difficult for those new to recovery, but for those who had the opportunity to improve their lives through treatment and appreciate spirituality in their lives, this could be an effective reminder that their Higher Power is still present in their lives. Community and group membership help tremendously with this, since there are other people around who are facing similar issues of faith and who are able to provide support and encouragement.

Another straightforward way of maintaining faith in trying times is to “stay close to God, [continuing] to strengthen my spirituality, getting closer to God’s will rather than my own,” as Caroline H. does.167 Caroline said that by trusting in God that there’s a purpose to her suffering, which may not entirely remove the suffering, but it does help “decrease my pain level and struggle.”168

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166 Brian L. Interview by author, 1 December 2012, Middletown.
168 Ibid.
For severe disruptions to faith such as suicidal ideation, Adam D., who had attempted suicide five times in his life, said he learned an important method of dismissing such thoughts as “just thoughts”:

If I’m practicing my faith and I’m active in my faith, you know, a thought can come into my mind, but I’m aware of the thought as just a thought. Even though I may not feel good, and I may feel poor [sic], I am able to push the thought out of my mind.\(^\text{169}\)

Given the nature of mental illness to warp thoughts and overwhelm one’s perception with negativity, this method, while difficult because one dismisses the very thoughts one’s mind is producing, seemed to be an effective way of distancing oneself from harmful thoughts. Having faith that the thought would pass was another important aspect of this approach; while someone may be in the grips of depression, knowing that the depression will lift at some point in the future is comforting.

Finally, Phil W., the Buddhist practitioner, seemed to transcend suffering in a different way, by altering his perceptions of “positive” and “negative.” Rather than viewing his condition or external events as such, he has “gotten to the point where everything is just happening…My experience is that the more I see and learn, the less painful experiences occur. They’re also not as intense as they used to be.”\(^\text{170}\) Phil does not deny that this detachment from judgment is a difficult thing to achieve, but said that it improves the more one tries to do it.

These four patients represented the perspectives of addicts, who may have been dual-diagnosis but were not necessarily. In the case of addiction, spirituality seemed able to be maintained in many trying circumstances because it was filling the

\(^{169}\) Adam D. Interview by author, 10 July 2012, New Haven.
\(^{170}\) Phil W. Interview by author, 18 January 2013, Skillman.
void previous occupied by drugs and alcohol. Mental illness complicates the ability to maintain spirituality because it involves significant aberrations in mood and behavior that are often out of one’s control when they occur. Most of the patients with mental illness said that during the most trying times of their conditions, spirituality in the form they previously practiced could not be maintained. The next section examines this case.

When Spirituality Cannot Be Maintained

Unfortunately, the reality of mental illness, as opposed to addiction, is that there are times when people cannot maintain spirituality to the extent they were able during periods of wellness because the mental turmoil patients were experiencing was too great. Patients spoke of needing to set aside or ignore religion during difficult episodes.

Jeff P., a dual-diagnosis patient with bipolar disorder, once couldn’t breathe while in the midst of a psychotic episode. When asked how he maintained spiritual belief during that time and times like it, he responded:

I often don’t [maintain spiritual belief]. In the worst of times, that’s when I find it really hard to think about God. When I couldn’t breathe and needed to call 911, I don’t think I thought about God until I was in the ER and they gave me Toradol [sic] so I could breathe again. It’s one thing to turn to God when it’s convenient, but it’s another thing to have an active faith when you’re in the throes of depression or psychosis.\(^\text{171}\)

Brandon A., a practicing Catholic, thought that faith did not always need to be an active event, but rather can “just be a state of being.”\(^\text{172}\) He said that during the most difficult times of his recovery, he metaphorically “put religion up on a shelf,” so he

\(^\text{171}\) Jeff P. Interview by author, 10 January 2013, Skillman.
\(^\text{172}\) Brandon A. Interview by author, 17 January 2013, Skillman.
could return to it at a later point when he felt better. More immediate measures such as hospitalization and medication adjustment are needed in times of debilitating depression or mania in order to reach a point of stability at which one can resume spiritual practices.

Finally, both Marie C. and Kate O. said that they too could not maintain spirituality when in the throes of episodes from mental illness. Marie said, “when I am emotionally flooded, it is hard to keep my spirituality in mind,” and Kate said “I pretty much abandon my spirituality going through the episodes.” Marie would try to center herself through meditation and Kate would try to reach out to support groups when she felt an episode coming on, but in both cases the mental illnesses overpowered spiritual practices during the time an episode occurred.

While these two sections have demonstrated that it is typically only mental illness, and not addiction, that can overpower spirituality during times of episodes, that is not to say that those in recovery from addiction do not face many challenges in the maintenance of their spirituality and faith. In fact, Step 11 of the 12 Steps of AA is entirely devoted to spiritual upkeep: “Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.” In the chapter on Step 11 in the *Twelve Steps and Twelve Traditions*, the book of complementary essays written on the steps and traditions of the program by co-founder Bill W., this encouraging passage is included:

173 Ibid.
174 Marie C. Interview by author, 20 November 2012, Middletown. Kate O. Interview by author, 5 November 2012, Middletown.
175 *Alcoholics Anonymous*, 59.
All of us [alcoholics and addicts], without exception, pass through times when we pray only with the greatest exertion of will. Occasionally we go even further than this. We are seized with a rebellion so sickening that we simply won’t pray. When these things happen we should not think too ill of ourselves. We should simply resume prayer as soon as we can, doing what we know to be good for us.\textsuperscript{176}

The message is simple and clear: everyone occasionally has difficulty praying, or sometimes does not pray at all—and this can be extended to other spiritual practices such as meditation, support group attendance, and others—but the key is to not let such challenges to our spirituality deter us from continuing to practice in the future. This is a message that applies universally to not only mentally ill and addicted patients, but even to those without such conditions. The difference is that, by nature of the mental conditions, such challenges to faith will occur more frequently in the lives of those suffering from mental illness and addiction.

**Clergy Perspectives**

When I asked clergy members the question about maintaining faith with the variation, “what advice would you give to patients struggling with this issue?” the responses were similar.\textsuperscript{177} What all of the responses essentially came down to was encouraging patients not to give up while facing doubt about and struggle with their faith, and to continue trying to incorporate and maintain spiritual practices in their lives even if it did not feel good. Belonging to a faith community or support group and continuing to attend in spite of how you feel was advice all of the clergy


\textsuperscript{177} It should be noted that the majority of clergy interviewed for this thesis ministered either at Yale University or Wesleyan University, two progressive northeastern institutions, so that could have been an influencing factor on the similarity of views.
encouraged. The specific approaches of the some of the clergy interviewed are as follows.

Wesleyan Rabbi David Leipziger and Yale Protestant Chaplain Ian Oliver shared two common points. First, that spirituality is a challenging thing to grapple with, with or without illness. As Rabbi Leipziger put it, “Faith is about doubt, doubt is about faith—that is the path. You can struggle, test, and get angry, but stay on this path of spiritual faith development for the long haul.” Second, developing one’s spirituality is a lifelong process, and one should not let the dark times of mental illness and addiction determine one’s spirituality during periods of wellness. Rev. Oliver encourages students to “think about [spirituality] in terms of the bigger picture of their life instead of the crisis of the moment.”

Imam Omer Bajwa, the Muslim chaplain at Yale University, takes a two-pronged approach, dealing with spiritual questions, such as “what is the meaning of suffering?” as well as spiritual practices, such as prayer and fasting. He says it is imperative to have both elements in order to maintain spirituality: “You can’t just do one or the other—all talk and no actions, or all action without understanding the meaning behind something.”

Similar to Imam Bajwa, Rev. Tracy Mehr-Muska, the Protestant chaplain at Wesleyan University, believed in a balance of talking about the philosophical issues surrounding recovery from mental illness and addiction, while also encouraging any spiritual practices that may appeal to the patient. Finding and joining communities of

178 Rabbi David Leipziger. Interview by author, 10 October 2012, Middletown.
180 Imam Omer Bajwa. Interview by author, 26 July 2012, New Haven.
181 Ibid.
faith was the first thing she mentioned was important for individuals trying to maintain spirituality, followed by “encouraging people to find spiritual practices that help them—prayer, yoga, journaling, counseling, meditation, things that are life-giving—and practice those as much as possible.”  

The common response of clergy, including the others I interviewed—Yale Buddhist chaplain Bruce Blair, Unitarian Rev. Katie Norris, and Baptist Rev. Maner Tyson—was to encourage patients to continue practicing, or even expand, their spiritual practices, as difficult as that may be in the throes of depression, cravings, and difficult life circumstances.

**Conclusion**

This chapter has examined the questions of how to reconcile belief in God with the pain caused by mental illness and addiction, and how to maintain spirituality in the worst times in recovery. The common element for those who managed to reconcile the two was an accepting attitude toward their condition and continued belief in God or a Higher Power, rather than blaming God for the conditions and suffering experienced or seeing their suffering as permanent. This was achieved through: the Christian perspective of sharing one’s suffering with that of Christ; striving to carry out a Higher Power’s will rather than one’s own; viewing aspects of one’s condition as assets rather than a liabilities; taking the attitude that things could be worse and being grateful for the good things one has; and finally, acknowledging that everyone faces challenges, has their “cross to bear,” or is “dealt their cards,” and

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182 Rev. Tracy Mehr-Muska. Interview by author, 6 February 2013, Middletown.
the best thing to do is simply accept those challenges and deal with them the best one can.

These were all examples of ways in which individuals “searched for meaning,” to use the term of Viktor Frankl. In *Man’s Search for Meaning*, Frankl writes that there are three different ways of finding meaning in life: “1) by creating a work or doing a deed; 2) by experiencing something or encountering someone; and 3) by the attitude we take toward unavoidable suffering.”\(^{183}\) The reconciling methods mentioned above are all examples of this third way of finding meaning in the “unavoidable suffering” of mental illness and addiction. Being part of a community of faith certainly gives people more access to the first two ways of finding meaning, and is especially important for the mentally ill and addicted, who may not otherwise have these opportunities due to the isolation caused by their illnesses.

On the second question about maintaining spirituality, there were two groups of patients—those who could maintain spirituality during the worst times of their recovery, and those who could not. It turned out that the addicted patients I interviewed were more able to maintain spirituality than mentally ill patients, because their sobriety was dependent upon their remaining spiritual and connected to their Higher Power. Unfortunately, for mental illness, while spirituality in a patient’s life may decrease the likelihood of an episode from occurring, it is no guarantee, and patients reported that when depressive, manic, or psychotic episodes struck, they largely had to set their spiritual practices aside until they were well enough to function again. Ultimately, regardless of whether or not spirituality was maintained

in moments of crisis, all of the patients affirmed Frankl’s statement: “In accepting this challenge to suffer bravely, life has a meaning up to the last moment, and it retains this meaning literally to the end.”

The perspective of the clergy I interviewed was unanimous. They were very understanding of the difficulties faced by those who suffer from mental illness and addiction, and encouraged them to try to remain spiritually engaged—whether that be attending a faith community or support group, praying, or meditating—even if it seemed difficult. All seemed to agree on the importance of a theoretical component, as well as the experiential component, and that both are crucial to a thriving spiritual program.

Having reviewed spirituality in health care, explored the types and effects of spirituality in patients, and considered the existential questions surrounding reconciling and maintaining spirituality facing these conditions from both patient and clergy perspectives, I next turn to examining why the medical field pays little attention to spirituality in mental health care, and what can be done to improve the situation.

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184 Ibid., 114.
Chapter 5: Resistance to Spirituality from the Medical Community

Until the past few decades, spirituality in mental health care had been paid very little, and even negative, attention by the medical community. As discussed in the opening chapter, the field of psychiatry was greatly influenced by the works of Sigmund Freud throughout most of the 20th century. This led to his influential writings on religion as an “obsessional neurosis” being adopted as the standard view on religion within the field and influenced subsequent generations of psychiatrists and psychologists.¹⁸⁵

Despite the residual effects of Freud’s negative thinking toward spirituality on the medical field, a shift is clearly occurring in terms of hospitals and training programs paying more attention to spirituality. The Joint Commission for the Accreditation of Hospital Organizations (JCAHO) requires that spiritual histories be taken on every patient admitted to acute care hospitals or nursing homes.¹⁸⁶ Veterans Affairs hospitals across the country have taken the lead in implementing a spirituality assessment for all patients, from which this thesis drew its broad definition of “spirituality.”¹⁸⁷ And many medical schools and residency programs have begun to incorporate courses and training programs to familiarize medical students and residents with spirituality in health care.¹⁸⁸

The problem remains, however, that the vast majority of doctors are not taking spirituality assessments of their patients. The Southern Medical Journal determined

¹⁸⁶ Koenig, Spirituality in patient care, 4.
¹⁸⁷ Department of Veterans Affairs, “Spiritual and Pastoral Care Procedures,” VHA Handbook 111.02, July 18, 2008.
¹⁸⁸ Koenig, Spirituality in patient care, 5.
through physician surveys that “…few [healthcare providers] today inquire about the spiritual needs of patients. In the United States, only about 10 percent of physicians often or always take a spiritual history, and nearly 50 percent never take one.”

What can be done to bridge this gulf that exists between doctors, patients, and a medical establishment seemingly taking proactive steps to incorporate spirituality into care?

**Health Care Perspectives**

From interviews conducted with psychiatrists and psychologists for this project, I determined there were three common reasons most of them do not incorporate spirituality into their treatment of patients. First, the lasting impact of Freud on the field has influenced many therapists to practice secular therapy, even after many of Freud’s ideas have since been abandoned; Second, psychiatrists are not reimbursed for discussing spirituality with patients; and third, spirituality has yet to be clinically proven as a specific treatment for mental health issues, rather than simply conflated with studies on the benefits of religion or the physiological changes that take place during meditation.

On the first reason, I spoke to a retired Yale psychiatrist who practiced in the heyday of Freudian psychoanalysis, and whom could speak to the influence of Freud’s anti-religious views on the field. Dr. Stan Leavy, who practiced psychoanalysis at Yale when he still saw patients, said, “therapists [should] try to evoke what’s in people, not impose things on them,” a sound philosophy that applies

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189 Ibid.
to most of psychotherapy. Dr. Leavy, himself a Christian who gains a great deal of comfort from his religion, said that his views on spirituality were irrelevant when it came to treating patients if the patients did not bring the topic up for themselves. However, something of great concern to Dr. Leavy was that “secular-minded therapists of our time tend to ignore religion and tend to look upon religion as kind of fluff—something they don’t need to address, that’s not very important.” The fact that most of his colleagues were secular and took this negative perspective toward spirituality led him to believe that not only was Freud’s lasting impact significant, but also that many patients for whom spirituality was important had the topic avoided altogether by their psychiatrists.

Whether one agrees or disagrees with Dr. Leavy’s psychoanalytic approach to not mentioning spirituality unless it is first mentioned by the patient, and only engaging the patient on the topic in the event that they do mention it, his concern about secular-minded therapists ignoring religion and spirituality entirely is a significant and valid one. As this thesis has demonstrated in chapters two, three, and four, there are myriad ways in which spirituality is a helpful complementary therapy for patients with mental illness or addiction, and denying patients the ability to talk about their spiritual lives in a safe and supportive environment is a major problem with the way psychiatrists practice.

The second reason, that talking about spirituality is not something psychiatrists are reimbursed for, is a significant one that Yale psychiatrist Dr. Michael  

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190 Dr. Stan Leavy. Interview by author, 13 July 2012, Hamden.  
191 Ibid.
Norko laments is “not within the power of psychiatrists to change.” The problem spans much further than psychiatrists simply not wanting to talk about spirituality with their patients; at the very core it’s an issue of psychiatrists not having enough time to practice talk therapy of any type and make a competitive salary by doing so.

Dr. John Schowalter, the Albert J. Solnit endowed professor of child psychiatry at Yale before retiring, traced the problem to the advent of managed care changing how psychiatric care was paid for in the late 1980s and 1990s. He pointed out that paying ahead with insurance coincided with more medications being brought to the market, so psychoanalysis and talk therapy were displaced by medication therapy. This is a well-documented trend that has led to insurance companies only paying for shorter 10-15 minute medication adjustment appointments rather than full one hour sessions to talk through the issues going on in one’s life. “Time and money are so linked,” he said, “that it’s easier to write a script…and hand it to them rather than tell them about transcendental meditation or other spiritual topics.”

A 2011 New York Times article entitled, “Talk Doesn’t Pay, So Psychiatry Turns Instead to Drug Therapy,” revealed that reimbursement is almost twice as much—$150 to $90—for three 15 minute medication visits rather than one 45 minute talk therapy session. Even more daunting, a 2005 government survey found that

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192 Dr. Michael Norko. Interview by author, 11 February 2013, Middletown.
193 Dr. John Schowalter. Interview by author, 11 July 2012, Hamden.
194 Ibid.
195 Ibid.
196 Gardiner Harris, “Talk Doesn’t Pay, So Psychiatry Turns Instead to Drug Therapy.”
only 11 percent of psychiatrists still provide talk therapy. Dr. Donald Levin, the psychiatrist interviewed for the article, conceded that switching to the short visit medication model is the only way to remain competitive, because psychiatrists do not want to “go back, moneywise, in their career.”

The time reimbursement problem for psychiatrists transcends talking about spirituality and more broadly affects talk therapy in general. This has required psychiatrists to get innovative with their time in order to accommodate patients, which has been difficult to do. Later in the chapter, the practices of psychiatrist Dr. Velandy Manohar will be examined as examples of the innovative strategies some doctors are implementing to improve patient care facing challenging time and money constraints.

The third reason, that spirituality has yet to be clinically proven as a specific treatment for mental health issues, is a well-taken concern. Many of the psychiatrists I interviewed raised questions they had about spirituality being used as a form of treatment if it wasn’t clinically tested and proven to work for specific conditions, similar to the process of approving medications.

This was a concern that almost all of the psychiatrists raised with spirituality being used in treatment. Dr. Ismene Petrakis, a Yale psychiatrist who works at the VA hospital in New Haven, raised the legitimate question, “what treatment are you talking about when you’re talking about spirituality? You can’t study it in any systematic way because it’s so individualized.” This is something that doctors and

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197 Ibid.
198 Ibid.
199 Dr. Ismene Petrakis. Interview by author, 15 July 2012, New Haven.
researchers such as Drs. Herbert Benson, Harold Koenig, Judson Brewer, and others are working on addressing in order to make progress on proving the health benefits of religion and spirituality.

At this point, the most reliable studies have been of people who already belong to religious communities and those who practice specific and standardized spiritual practices such as meditation. A concern that Dr. Michael Norko raised is that these studies have typically been conducted on individuals who are already religious or practice of meditation rather than people practicing for the first time: “The data do not demonstrate the efficacy of ‘prescribing’ religious practices—especially to people who are not inclined to engage in them by virtue of their own values and experiences.”

200 This highlights an important point that has not yet been addressed. Neither this thesis nor any of the thinkers cited in it are advocating for the “prescription” of spirituality or religion to patients. Rather, the purpose of the thesis is to draw attention to the fact that spirituality has been an important complementary component of many patients’ recovery programs, and that psychiatrists and other caregivers could better help patients if they paid attention to their spiritual lives.

Dr. Joseph Goldberg of Mt. Sinai School of Medicine and Dr. Judson Brewer of Yale Medical School both agreed that more evidence would have to be presented before spirituality, or specific types of spiritual practice, became mainstream treatment. Dr. Goldberg was concerned that randomized clinical trials had not yet been conducted “examining the outcome of treatments that incorporate spirituality

200 Dr. Michael Norko. Interview by author, 11 February 2013, Middletown.
from those that do not for treating any psychiatric disorders.” Dr. Brewer saw the issue not as spiritual versus medical but evidence-based versus non-evidence-based. Certain medical treatments, such as transcranial magnetic stimulation (TMS) are far from proven, while practices such as meditation have a growing body of research literature supporting their positive affects on the brain. Dr. Brewer cautioned against those who “tout therapies as being fabulous without any evidence, [because] they’re going to draw resources away from treatments, spiritual or other, that are effective.”

While psychiatrists who avoid spirituality in therapy may do so for these three reasons, not everyone agrees upon the medical model alone being the best method of treatment. Lee Albert, a social worker at the Hartford Institute of Living and leader of a spiritual support group there, challenged doctors who brush aside spirituality, when she’s personally seen it to be a tremendously helpful complement to other therapies for patients:

The thoughts [from the medical community] are that spirituality is therapy-lite and that [doctors are] doing ‘real’ therapy…Psychiatry tends to embrace the medical model—“I am the expert and you are the receiver of my expertise.” Take a pill and it makes you feel better, and some of them do. You can’t really quantify spirituality in the same way, though.

Ms. Albert is advocating for a model of care in which doctors and other caregivers do not dismiss a therapy just because it is outside their area of expertise. Rabbi Leipziger echoed this sentiment of respecting other treatments and caregivers, as well: “Imagine if I, as a clergyman, told someone not to seek out a therapist. That

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201 Dr. Joseph Goldberg. Interview by author, 23 January 2013, Middletown.
204 Lee Albert. Interview by author, 10 July 2012, New Haven.
would be criminal. Psychiatrists, clergy, and patients should all be on the same page when treating someone.”

**Patient Perspectives**

The patients interviewed for this thesis were split between having psychiatrists and psychotherapists receptive to spirituality and having ones that were not. A majority of the patients said that their psychiatrists never address spirituality with them, while most psychotherapists did and were very respectful of personal beliefs. This most likely reflects the second reason of time reimbursement constraints for psychiatrists not discussing spirituality. Other patients described their psychiatrists as outright judgmental or disrespectful toward their spiritual beliefs and practices.

Some patients were fine with the arrangement of seeing their psychiatrist for medication and their psychotherapist for talk therapy in which they would discuss spirituality, but others thought they weren’t be treated holistically, as whole people. Olivia R. wanted a psychiatrist “I can spend time with, who knows me, and who can actually treat me.” Instead, what she has received throughout her years of seeking treatment has been “being treated like a number.” Marie C. said, “I don’t think [psychiatrists] cared that much [about my spirituality] anyway—their job is to prescribe medications.” It’s difficult to know whether psychiatrists did not care about a patient’s spiritual life or simply did not have the time to address it, but either way this was a recurring problem patients faced.

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205 Olivia R. Interview by author, 11 July 2012, New Haven.
206 Ibid.
207 Marie C. Interview by author, 20 November 2012, Middletown.
Worse than psychiatrists not paying attention to spirituality is psychiatrists who actively take a negative stance on it toward their patients. Brandon A., a practicing Catholic, was never sure what to think about his spiritual practices in the context of his recovery from bipolar disorder because he received such mixed messages: “I had one person tell me that I should be praying, and I had other people tell me that it’s a form of psychosis and that I shouldn’t be praying.”

Author Kimme Carlos stopped seeing her psychiatrist and has been handling management of her anxiety with her primary care doctor for years because when she would talk of her relationship with God to her therapists, she “didn’t feel like I was respected.”

These descriptions all seemed to confirm that there should be some significant changes to the way psychiatrists approach spirituality, as it can be a disservice to patients who are trying to cultivate all aspects of their recoveries—medication, psychotherapy, group therapy, spirituality, exercise, and nutrition.

**Toward a New Model of Holistic Care**

Dr. Velandy Manohar, chief psychiatrist at the Community Health Center (CHC) in Middletown, CT, challenges the status quo with his views on the current state of psychiatry and the role spirituality plays in treating patients. The CHC is an innovative patient-centered medical home whose mission is to provide “quality health care services…to all, and particularly those who cannot gain access to such services elsewhere.”

Much of what the CHC and its doctors do challenges status quo medicine: rather than accepting gross inequality in access to care and an existing

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208 Brandon A. Interview by author, 17 January 2013, Skillman.
model that makes more money for doctors when patients are sick, the CHC strives to bring quality care to those who need it most and compensate doctors based on improved health outcomes of patients. It was inspiring to see how progressive both Dr. Manohar and the CHC are in their approaches to treatment.

Dr. Manohar had a clear definition of spirituality that he used in his treatment of patients, and that he thought could be more widely incorporated into the field of psychiatry. As he sees it, there are four critical components of a psychiatric assessment, and spirituality is one of them:

The first is, obviously, is there something important we have to deal with medically, in a physical plane? The second is, are there things happening in the psychological, internal experience of the individual based on recent or past experiences in how they’re dealing with you and with their issues? And the third is, are they suffering from recognizable, known psychiatric disorders? The fourth area of spirituality includes the degree of isolation or social connectivity. The more isolated, unlike cases of monks who are extremely spiritual in their isolation, our patients who are severely isolated are also extremely spiritually lost. \(^{211}\)

Interestingly, Dr. Manohar includes an entire level of assessment for spirituality, using the very broad definition of “social connectivity.” Some of the other psychiatrists interviewed neither had clear definitions for spirituality, nor did they talk about how they incorporated it into their model of care. The consensus in psychiatry, which Dr. Manohar challenges, seems to be that spirituality and psychiatry are separate domains, and spiritual care should be left to pastors and clergy instead of the psychiatrist also taking interest in it.

Despite challenges to incorporating spirituality into patient care, Dr. Manohar is hopeful for the future, and points to a number of successes over the years that have

\(^{211}\) Dr. Velandy Manohar. Interview by author, 17 July 2012, Middletown.
established greater awareness and following of spiritual practices. Dr. Manohar enthusiastically noted that spirituality is being paid attention by some in the fields of medicine and psychology:

Some aspects of it are [being paid attention]. Clearly, certain forms of yoga and meditation are thoroughly encouraged. Chanting a certain word to get into a meditative state need not be deity-based. That is well-integrated into general medicine now. Before one of my professors at Harvard, Dr. Herb Benson, in ’69, ’70, ’71, did research at the Brain/Body Institute, that wasn’t the case. Dr. [Jon Kabat] Zinn, a psychologist at UMass took a basement place and completely changed it—he has this whole institute almost. 212

Surely just broaching the topic of spirituality with patients must be difficult, especially those who may have had negative experiences with religion in the past or who may be opposed to incorporating spiritual practices in their lives. Dr. Manohar’s approach is not forcing anything on a patient—and this extends to medications and psychotherapy, too—but taking the time to tease out what the best outcome will be, keeping in mind the definition of spiritual as “socially-connected,” not isolated:

Most people discuss religion, spirituality, theology in certain ways—I believe in that too. For example, if somebody asks me about scripture, and is from a Christian culture, I will say “these are the readings that I found helpful,” and I won’t mind telling them. They can look it up and then come back and talk to me. And so I give them these things, I ask them what they read. I am suspicious if they are spending too much time on Revelations, whether they’re going to get too caught up in it. It’s very safe to look at the Sermon on the Mount, Matthew 27, about separation because most of my patients are very warm-hearted people who get into a mess from being in relationships where they’re taken advantage of. There are many scriptures that are uplifting for them to read. I don’t mind going directly to the source.

This approach of asking about the patient’s background and then trying to tailor the spiritual recommendations one makes to that background seems ideal. If a patient is not religious but suffering from mental illness or addiction, Dr. Manohar may suggest

212 Ibid.
support groups, such as AA or DBSA, for them to attend. AA happens to be a faith-based program, but other support groups, such as DBSA focus more on providing a safe place where people can talk about their issues—and increase connection with other people in the process. To Dr. Manohar, the most important consideration is one’s level of connection with other people, recognizing that loneliness and isolation are typically the worst symptoms of these disorders, and can lead to worse things such as self-harm and suicide. Whether that connection is achieved through attending church, support groups, or better relations with family members, what matters most is achieving the end result of avoiding isolation.

Dr. Manohar’s approach to psychiatry was refreshing. He is not anti-medication; in fact, he notes that with major mental illnesses such as schizophrenia, bipolar disorder, and major depression, patients will “usually not” ever come off of their medication. However, he says, “They may be taking five medications, which could be a huge mistake, and I will work with them to get down to one or two medications.”213 He reiterated that he would not recommend spiritual practices as an alternative to medication and psychotherapy. As he sees it, the three approaches are complementary and improve the chances of the other two working. Psychiatrists who do not use this holistic approach, Dr. Manohar says, “are paying little to no respect to the psychiatrist’s creed that it’s a threefold assessment.”214

Psychiatrists should be using every tool at their disposal to ease the mental suffering of their patients. Unfortunately, in the past few decades, psychotropic medication has dominated other forms of therapy, including psychotherapy and any

213 Ibid.
214 Ibid.
inquiry about a patient’s spiritual background. According to Dr. Manohar, this shift had a lot to do with insurance companies and compensation issues. Despite constraints on time, however—Dr. Manohar typically only sees patients for 15-20 minutes—he still manages to gain an understanding of how a patient is doing on the whole—physically, mentally, and spiritually. The path forward to revitalizing holistic psychiatry is not an easy one, especially considering how profitable and easy to deliver psychotropic drugs are. If doctors don’t consider the risks of one-dimensional care and start incorporating spirituality assessments and resources into their work with patients, unfortunately a very important part patient wellness will be ignored.

**Conclusion**

The path moving forward is not an easy one for patients who benefit from spirituality in their treatment. It seems that many of the necessary measures have been taken on a broad scale to implement reforms that bring spirituality back into the fold, such as the JCAHO and VA required spirituality assessments, but the fact remains that many doctors don’t comply with those requirements. As this chapter points out, that could have to do with the lasting impact of Freudian anti-religious thought on the field of medicine, especially psychiatry, that can still be seen today. Whatever the cause, it seems unlikely that the current generation of doctors, in which only 10% of them always inquire about the spiritual needs of a patient, will be the one to bring spirituality as a complementary therapy into the mainstream. Medical schools and residency training programs will have to better instill the importance of
inquiring about a patient’s spirituality, and if there are any resources (e.g. access to a chaplain, a space to pray or meditate, literature, etc.) they can help get the patient.

Finally, while spirituality can mean very different things to different people, it is important to note that the same search for meaning and purpose in one’s life, as defined in chapter one, is part of the human condition. It is this universality that makes it an important therapy for the mentally ill and addicted as well. Unlike many other therapies, Yale psychiatrist Dr. Oscar Hills says, spirituality is not a fad that will be moved away from, as many other treatments in recent history have:

We always hope that the solutions to problems of living will be simpler than they are. Early in the twentieth century in psychiatry, we had Freud and psychoanalysis. In the late 1950s and 1960s, revolutionary medications began to appear...Between then and the 1970’s and early 1980’s, various forms of psychotherapy were also popular, until the focus became more biological and medication-focused again in the late 1980’s and the 1990’s. Now, there seems to be disappointment in medication treatment, and there is a resurgence of new psychotherapies, some with fairly impressive results. Ultimately, the treatment pendulum tends to swing between mind and brain, but the results have as yet to be as robust as we wish then to be at either extreme.²¹⁵

While the medical field may always be striving for the best treatment and “swinging” over time between mind (psychotherapy) and brain (medication) treatments, what it may have ignored altogether was the significance of patients’ spiritual beliefs, something that has continued to affect people throughout history.

²¹⁵ Dr. Oscar Hills. Interview by author, 8 January 2013, Skillman.
Conclusion:

This thesis has shown that spirituality can greatly benefit the recovery of individuals suffering from mental illness and addiction. However, it also concludes that spirituality has thus far not been paid adequate attention by the medical community. The process of reaching these conclusions involved: setting out clear definitions of the terms “spirituality,” “mental illness,” and “addiction,” in chapter one; considering the benefits of spirituality on general health and the parallels that exist to mental health in chapter two; examining the different types, though similar effects, of spirituality practiced by patients in chapter three; exploring the existential question of how to maintain faith during the most difficult times in recovery in chapter four; and finally questioning why the medical community has been divided on the question of spirituality in recent decades, as well as what can be done about this, is chapter five.

The aim of this thesis—to aggregate historical, contemporary, and first-hand perspectives into a comprehensive argument for the importance of spirituality in mental health care—was ambitious but possible, for three reasons.

First, in the books I read while preparing my questions for the thesis, there was little overlap of historical and contemporary views on the topic, something I felt needed to be changed. For instance, one could read Sigmund Freud, Carl Jung, or Viktor Frankl to gain an understanding of early twentieth century views toward spirituality, but would have little understanding of the intellectual development on spirituality that’s taken place in the past two decades by thinkers such as Dr. Harold Koenig, Dr. Larry Culliford, and Dr. Judson Brewer, to name a few examined in this
thesis. The integration of these varied perspectives into a coherent whole was the aim of chapters one and two.

Second, while some of the books I read while researching for this thesis included stories of individual patients, I did not find any works that examined a larger group of patients—15 in the case of this thesis—and identified common aspects across their different experiences. Chapters three and four, examining in depth the types and effects of different spiritual experiences patients had, as well as how they maintain that spirituality during trying times, are original contributions using patient and clergy testimony.

Third and finally, while some works acknowledged the absence or ignorance of a spirituality assessment in patient care as a problem, there seems to be very little dialogue about what can be done to address the problem. Through looking at the comprehensive, holistic approach to psychiatric care of Dr. Velandy Manohar, chief of psychiatry at the Community Health Center in Middletown, CT, one sees that it is possible to ask patients about their spiritual backgrounds during short visits, and depending on the patient’s receptiveness to spirituality, even ask if they would like to incorporate some prayer or meditation into their life. This could lead to referrals to chaplains, religious or faith communities in the area of the patient’s faith background, and more importantly the patient feeling empowered by having a caregiver respect and support this aspect of their life and recovery. This would likely be very valuable in alleviating some of the intense suffering experienced by the mentally ill and addicted.
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Appendix: Interview Questions

Medical Professionals:
1. What definition of spirituality are you working with in your clinical work? (What’s the party line of spirituality that’s being handed out in the mental health fields?)
2. What is the thinking on spirituality in the field and where do you fit into that? Are there any books or articles on the subject that you’ve been reading and incorporate into your treatment? Spearheading an effort? Uninvolved?
3. What’s the state of the field right now on the question of using spirituality in treatment?
4. How do you define spirituality?
   a. Do you see any differences between spirituality and religion?
5. What do you think the role of spirituality and faith is in the healing process from mental illness and addiction?
   a. Important – Do you think it is currently being paid enough attention in the psychiatric/clinic psych community as an effective therapy?
   b. Neutral – Why? You’ve seen the same treatment results with both spiritual and non-spiritual people?
   c. Negative – Barring religious hallucinations, which everyone agrees to be negative and treatable with medication, what are ways in which the moderate practice of spirituality in one’s life can actually create negative outcomes?
6. Why is spiritual therapy almost never mentioned in mainstream sources like the Mayo Clinic, and the first therapies that are mentioned are usually medication (psychopharmacology), talk therapy (psychotherapy, CBT, DBT), or group therapy?
   a. If you ask about AA as group therapy, say there was one mention of AA/12-Step programs on the site with no information about it; and no use of the word spirituality on the site.
7. What is your view on clinical studies that have been conducted, such as those by Dr. Harold Koenig at Duke, which demonstrate better health for individuals who believe in God and pray more?
8. Do you think the psychiatric profession has become more dependent on short appointments and medication treatment than holistic therapy that addresses biological, psychological, and social needs (spirituality included in the latter two)?
   a. If Yes, what do you think can be done to reform the profession and get holistic therapy back on track?
   b. If No, mention NYTimes article in which a psychiatrist talks all about insurance companies only paying for shorter visits where the doctors barely get to know the patients. “Fragmented care”
9. Do you currently incorporate any sort of non-denominational spiritual support or encouragement in your therapy? Do you model this on a particular program?
10. If spirituality up to this point has not been paid adequate attention and utilized as a therapeutic tool for the mentally ill and addicted within the medical community, what measures do you think can be taken to incorporate it into a more balanced, holistic care model?
11. What would be your concerns with a resurgence in spiritual/religious therapy and how do you think those concerns can be mitigated?
12. If you feel comfortable answering this, I would be interested to know: If/Do you consider yourself a religious or spiritual person, and if so, how does that affect your day to day life, profession, and coping with challenges in life?
(Save until the end of the Interview)

Clergy:
1. How do you define spirituality?
   a. Do you see any differences between spirituality and religion?
2. How do you react when an individual suffering from mental illness or addiction comes to you for help?
   a. Talk/pray?
   b. Get the person medical help immediately?
3. What do you believe the role of spirituality and faith is in the healing process from mental illness and addiction?
4. Have you been involved in any projects involving mentally ill or addicted patients?
5. What is the right balance between traditional medicine and spirituality, and how/do you encourage those asking you for help to seek both and not one at the exclusion of the other?
6. How do you address the views of non-mentally ill/addicted toward those who suffer from these issues? Is there a stigma or misunderstanding that you try to clear up through your work?
7. What do you think accounts for spirituality being seen as something separate from the treatment of mental illness and addiction by those in the medical profession? If so, why?
8. What is the best advice you would give to someone, who is either still struggling with their illness or struggling with depression, cravings and other difficult conditions in recovery, on how to maintain their spirituality or faith?
9. If you feel comfortable answering this, I would be interested to know: How does spirituality/religion affect your day to day life, profession, and coping with challenges in life?

Patients:
**I will have inquired before to ensure the participant has been seeking treatment/in recovery (sober) for over 1 year, so questions 1 and 2 are to find out lengths of time beyond that.
1. How long have you suffered from mental illness and/or addiction?
2. How long after you started to experience symptoms did you seek treatment? How long have you been in recovery?
3. What types of treatments have you used? Has spirituality been a part of your treatment program? How did your professional treatment program relate to your use of spirituality? Was it something offered to you or did you find it on your own?

4. What do you define spirituality as?
   a. Do you see any differences between spirituality and religion?

5. Has some sort of spiritual practice been part of your treatment?

6. When did spirituality become a part of your treatment/therapy?

7. Have you found that psychiatrists and psychologists have been respectful and supportive of your spirituality?

8. What types of spiritual practices do you do in your life?

9. What has been the effect of spirituality on the symptoms of your mental illness/addiction?

10. How do you balance your spirituality therapy with other forms of therapy—medication, psychotherapy, exercise and nutrition, etc.?

11. How do you reconcile spirituality and belief in God with your mental conditions and the pain they cause you?

12. How have you managed to maintain spiritual belief and faith in the worst times of your recovery—battling with depression, anxiety, cravings, difficult life circumstances, etc.?

13. How would you recommend those who are suffering from untreated mental illness or active addiction begin the process of recovery?
   a. When is the appropriate time to incorporate spirituality into one’s healing process?

14. What would you recommend to people who’ve had negative experiences with religion in their past and seem unwilling and uninterested in trying spirituality?

15. How do you think the community of mental illness and addiction sufferers whose lives have been profoundly changed by spirituality can have its voice heard by the medical and religious communities to help eliminate any stigma that may exist?