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THE MYSTICAL AND MENTAL HEALTH

CATHERINE RACINE

Introduction. The new field of research on spirituality, theology and mental health has grown exponentially in the past decade, and is on the cusp of becoming a recognized sub-specialty of medicine only a few centuries after the Enlightenment, when science and religion became estranged from each other[1]. Until recent times, priests took care of the mentally ill in monasteries although today churches, synagogues, mosques and temples are still involved. Prior to 2001, it was estimated that clergy offered 150 million hours of mental health support, per year, in America alone[2].

While studies done in the US form the largest part of this new field of research, scholars from many countries, including Canada, have demonstrated that the positive health outcomes related to religion and spirituality are reported across cultural and religious boundaries[3]. Evidence surrounding the study of spirituality, theology and mental health has been consistent and significant, if not unequivocal. There are many measurable and important benefits being identified[4].

This emerging area of research is now recognized by the WHO, and by the Royal College of Psychiatrists' 'Spirituality Special Interest Group'. The

[1] Harold G. Koenig, Michael E. McCullough, David B. Larson, *Handbook of religion and health*, Oxford, New York: Oxford University Press, 2001; Dan G. Blazer, „Religion, spirituality, and mental health: What we know and why this is a tough topic to research", *The Canadian Journal of Psychiatry / La Revue canadienne de psychiatrie*, 2009, t. 54 (5), p. 281–282.

[2] Andrew J. Weaver, Judith A. Samford, Amy E. Kline, Lee Ann Lucas, David B. Larson, Harold G. Koenig, „What do psychologists know about working with the clergy? An analysis of eight APA journals: 1991–1994", *Professional Psychology: Research and Practice*, 1997, t. 28 (5), p. 471.

[3] Marilyn Baetz, John Toews, „Clinical implications of research on religion, spirituality, and mental health", *The Canadian Journal of Psychiatry / La Revue canadienne de psychiatrie*, 2009, t. 54 (5), p. 292–301.

[4] Harold G. Koenig, „Research on religion, spirituality, and mental health: a review", *Canadian Journal of Psychiatry*, 2009, t. 54 (5), p. 283–291.

American College of Graduate Medical Education states that all psychiatric programs must now include training on religious and spiritual factors influencing psychological development[5]. A growing number of medical schools in Canada are also offering such training[6].

Even so, the field is in its infancy[7], and scholars are still deciding on nomenclature and definitions while exploring where religious or mystical experience and mental illness begins, ends, and intersects[8]. There are many issues involved in this emerging field that are being hotly debated, including the appropriateness of clinicians praying with, or for, their patients[9]. Researchers and health care professionals of all stripes are still learning to navigate this emotionally charged and polarizing field[10]. The emerging issues are blurring the lines between medicine and theology, and between all the disciplines that constitute the various professions represented on interdisciplinary mental health teams. These issues are, in turn, expanding and challenging professional boundaries of practice, while inviting the numinous into a closer dialogue with empirical science.

Mysticism and Mental Health Practice. Mental health professionals are still largely hidden in their research, and trained to recognize quantitative research as the gold standard, even in the study of theology and spirituality. There is still very little in the current literature on the mystical experience of mental health professionals themselves. The natural reticence as humans

[5] *Ibid*.

[6] Andrea D. Grabovac, Soma Ganesan, „Spirituality and Religion in Canadian Psychiatric Residency Training", *The Canadian Journal of Psychiatry / La Revue canadienne de psychiatrie*, 2003, t. 48 (3), p. 171–175; Andrea Grabovac, Nancy Clark, Mario McKenna, „Pilot study and evaluation of postgraduate course on 'The interface between spirituality, religion and psychiatry'", *Academic Psychiatry*, 2008, t. 32 (4), p. 332–337; Harold G. Koenig, „Research on religion, spirituality, and mental health: a review".

[7] John Swinton, „Identity and resistance: why spiritual care needs 'enemies'", *Journal of clinical nursing*, 2006, t. 15 (7), p. 918–928.

[8] Harold G. Koenig, Michael E. McCullough, David B. Larson, *op. cit.*; Chris C. H. Cook, „Psychiatry and mysticism", *Mental Health, Religion & Culture*, 2004, t. 7 (2), p. 149–163; Charles P. Heriot-Maitland, „Mysticism and madness: Different aspects of the same human experience?", *Mental Health, Religion & Culture*, 2008, t. 11 (3).

[9] Chris C. H. Cook, „Commentary on... Spirituality and religion in psychiatric practice", *The psychiatrist*, 2010, t. 34 (5), p. 193–195; Michael King, Gerard Leavey, „Spirituality and religion in psychiatric practice: Why all the fuss?", *The Psychiatrist*, 2010, t. 34 (5), p. 190–193.

[10] Marilyn Baetz, John Toews, *op. cit*.

to speak openly about such experience contributes to the problem[11]. But the profoundly spiritual engagement that can emerge in the course of the intimate therapeutic relationship with the vulnerable 'other', is missing from the literature. While John Swinton[12] observes that spirituality and nursing are in a state of static equilibrium, with limited radical thinking or critical appraisal, this may also be said of all clinicians who participate on interdisciplinary mental health teams. In the face of this new research, it would seem that clinicians are all engaged in what Swinton describes as identity formation, and possibly spiritual formation, as they consider the vast implications of uniting science with spirit. Bringing the embodied mystical experience of clinicians into the dialogue may help forward the praxis of theology, spirituality, mental health, and the study of Christian mysticism offer a vehicle for that endeavour.

Christian mysticism is rarely addressed in the research on spirituality, theology and mental health although it is connected to an immense body of literature[13]. Despite the ongoing debates between the secular and the religious, and the mushrooming interest in Buddhist practice in the West, Christian mysticism is suggested as a point of departure because „the Western imaginary is saturated with images, values and symbols derived from the Judeo-Christian heritage"[14]. Jantzen's observation also comes with a warning: „Whether we like it or not the biblical texts and religion built upon them have shaped the consciousness of Western civilization; and we cannot, without violence to ourselves, cut ourselves off from our own formation"[15].

Despite psychology's current fascination with 'mystical experience', there has been an historical struggle in psychology's tentative relationship with theology. Mystical scholars[16] point out, however, that this powerful

[11] Abraham H. Maslow, *Toward a psychology of being*, New York, London: Van Nostrand Reinhold, 1968; David Hay, Pawel M. Socha, „Spirituality as a natural phenomenon: bringing biological and psychological perspectives together", *Zygon*, 2005, t. 40 (3), p. 589–612.

[12] John Swinton, *op. cit*.

[13] Mark A. McIntosh, *Mystical theology: The integrity of spirituality and theology*, Oxford: Blackwell, 1998; Bernard McGinn, *The essential writings of Christian mysticism*, Random House of Canada, 2006.

[14] Grace M. Jantzen, *Becoming divine: Towards a feminist philosophy of religion*, Bloomington, Ind.: Indiana University Press, 1998, p. 14.

[15] *Ibid*., p. 107.

[16] Grace M. Jantzen, *Power, gender and Christian mysticism*, Cambridge: Cambridge University Press, 1995; Mark A. McIntosh, *op. cit*.; Bernard McGinn, *op. cit*.

affective experience was often understated, or not even mentioned in the accounts of early mystics, and while never insignificant was part of a much larger, communal and coherent context. Of greater import was a life-long commitment to rigorous spiritual practice and asceticism. The path to the knowledge of God was through the arduous journey of purgation, illumination and contemplation, or union, with God. McIntosh notes that a more accurate description of 'mysticism' might be understood as 'contemplation' which, „in earlier eras referred to the most intimate and transforming encounter with God", while the term 'mysticism' is „something of an academic invention"[17]. The early mystics were primarily dedicated to the quelling of the passions, the development of the inner life, the refinement of consciousness and the focus on the relationship, or intention toward a relationship, with God that was informed and mediated by Christian thought and ritual.

In mainstream mental health, pathology is still the primary focus of inquiry. The dehumanizing process of objectifying and labelling the mentally ill, the disabled and the intellectually challenged, is analysed in the work of John Swinton[18], Simon Williams[19], Paula Caplan[20], and most tenderly by Jean Vanier[21]. It is a process written into the DNA of community mental health practice, and the vast financial economy connected to it, in which clinicians freely participate for their daily bread. Community mental health care is an economy run largely on assessment, prescription medication, and the taxonomy of emotion and circumstance, and it is fed with the most damaged and disenfranchised living within the community. Here is where the call to love seems so urgent.

Deepening an understanding of the 'mystical', and the love it embodies within the context of Christian mysticism, may help counterbalance the many professional prohibitions of 'loving' within community mental health practice. It may also help to shift 'professional' focus away from pathology and diagnosis, towards community models such as L'Arche[22], for example,

[17] Mark A. McIntosh, *op. cit*., p. 11.

[18] John Swinton, *Resurrecting the person: Friendship and the care of people with mental health problems*, Nashville: Abingdon, 2000.

[19] Simon Williams, „Reason, emotion and embodiment: is 'mental' health a contradiction in terms?", *Sociology of Health & Illness*, 2000, t. 22 (5), p. 559–581.

[20] Paula J. Caplan, *They say you're crazy: How the world's most powerful psychiatrists decide who's normal*, Reading, Mass.: Addison-Wesley, 1996.

[21] Jean Vanier, *Becoming human*, London: Darton Longman & Todd, 1999.

[22] *Ibid*.

that could better address the psycho-spiritual and practical needs of the stigmatized, isolated, and profoundly lonely clinical population accessing community mental health. Equally important, such dialogue may encourage greater transparency in the research about clinicians' involvement in the often devastated lives of those they serve. These lives provide clinicians themselves with meaningful experience of community, virtually unreported in the literature. In sum, a more substantial dialogue on love could support the mental health care industry in confronting the larger truths about the fundamental imbalance of power within the therapeutic relationship, and the social, economic and cultural determinants of emotional distress so often labelled as 'mental illness'[23].

Possibly the most pressing reason for clinicians to bring greater transparency about their own spiritual and mystical narratives to the research, particularly within the context of their work, is the current state of mental health itself. In British Columbia, Canada, for example, it is business as usual in an increasingly cash strapped community mental health system where case loads are growing in complexity and number, and staff members stagger under the weight of responsibilities that place everyone at risk. There is neither the time nor place for religion or spirituality, let alone for the needs of vicariously-traumatized staff[24]. In the pressure-cooker of such a system, professional behaviour too often belies an unsettling, and unacknowledged, resentment towards those being served, especially those in greatest need: the homeless, the addicted, and the traumatized. Thus, the exponential growth of literature on spirituality, theology and mental health in the past decade, while astonishing to witness, provides scant comfort in such an environment, and points to the absence of a theology of practice.

If mystical experience must precede theology and evolve from it[25], community mental health cannot ethically, or adequately, realign its praxis to recognize and call forth the most profound spiritual dimensions of human experience without bringing the lived experience of clinicians firmly into the dialogue. A remarkable example of the transparency called for in such research is to be found in the work of Canadian humanitarian Jean

[23] Simon Williams, *op. cit*.

[24] Sean Collins, Ann Long, „Too tired to care? The psychological effects of working with trauma", *Journal of Psychiatric and Mental Health Nursing*, 2003, t. 10 (1), p. 17–27.

[25] Thomas Merton, *An Introduction to Christian Mysticism: Initiation Into the Monastic Tradition 3*, edited with an introduction by Patrick F. O'Connell, Kalamazoo, Michigan: Cistercian Publications, 2008.

Vanier[26]. The way is not yet clear, but there is much to be gained if and when clinicians step out from behind the protection of objective empiricism and reveal their own spiritual selves within the context of their work.

Jean Vanier. Canadian Christian humanitarian, Jean Vanier[27], who has dedicated his entire life to building community with the developmentally delayed, models the kind of love mental health professionals may well have reason to fear. It is a love that, in mystical terms, recognizes the other as the reason for our existence, for whom we are ultimately and absolutely responsible, and to whom we are irrevocably connected. Although Vanier is a powerful man who has enjoyed a high profile for his work, his resistance to hierarchy, his recognition of the deep well of loneliness in all human beings, including himself, and his dedication to an ideal of community where every member is celebrated and equally valued, is radical and relevant to the issue of loving in the context of community mental health.

Vanier's most valuable achievement may well be his open invitation to witness his own personal need. He is fearless in identifying himself as a being whose need for love is as great, or greater, than those he has spent a life-time serving. In so doing, he invites mental health professionals into the risky consideration of their own need for love, which they can admit to if not embrace, when they are able recognize the unique and priceless contribution made by each individual who accesses mental health, no matter how differently-abled. He stands at the margins, with the oppressed population he has spent a life-time championing, and acknowledges his profound need for *their* love.

Vanier identifies five different 'attitudes' that can be taken towards individuals with developmental delays. The first of these bears the greatest likeness to how clinicians operate within a mental health setting, which is to see the disability (dis-ease) as a sign of a disorder. The last of these attitudes, which unfolds along a continuum of increasing valuation, is to recognize that „people with disabilities are necessary for the wholeness of the body of humanity"[28]. It may be argued that there are significant differences between development disabilities and mental illness, and these are understood, but

[26] Jean Vanier, *Essential writings*, selected with an introduction by Carolyn Whitney-Brown, London: Darton Longman & Todd, 2008.

[27] Jean Vanier, *Community and growth*, London: Darton Longman & Todd, 1989; Jean Vanier, *Becoming human*; Jean Vanier, *Essential writings*.

[28] Jean Vanier, *Essential writings*, p. 48.

Vanier's work offers an illuminating example of how professionals may begin to consider loving within clinical practice.

The therapeutic relationship recognized in mental health as primary to the needs of those who come for help is, according to Vanier's example, the same relationship from which the 'helpers' also benefit. Thus, the one who has come for help is also revealed as a helper and way-shower. The vulnerable other mirrors back the clinician's own desire for connection. Within his story and his suffering, the mental health clinician can more clearly recognize a fellow traveller and friend on a spiritual path, not unlike her own.

By recognizing love for this 'other', priorities and actions can shift. The need to self-protect within institutional constraints can be eased as clinicians claim their place beside, not above, the one who gives their life meaning, and who reveals to them their human, not professional, responsibility. As a starting point, mental health professionals would need to confront not once, but repeatedly, the privilege of their roles and authority by being more transparent about their own humanity with the people in their care, with colleagues, and within the research. But this would only be the beginning.

The experience of working with those labelled with a mental illness, and of witnessing their transformation through the course of our work together, has indeed disturbed my own professional equanimity. To recognize and experience the other as sacred is to be confronted by the enormity of my own privilege, and my moral responsibility to create community and justice for my afflicted friend, despite the significant limits imposed by my workplace, and the theory of my practice as a therapist.

Conclusion. In sum, bringing love into the dialogue has far reaching implications for the field of spirituality, theology and mental health, and specifically for community mental health professionals. These impinge on issues related to identity formation, spiritual formation, and to the re-evaluation of pathology and practice. Moreover, a closer consideration of the role of love within clinical care may contribute to the ongoing evolution of a practical theology that can discern and acknowledge, with greater courage, the shadow side of mental health practices, and the hierarchy it maintains. Psychiatrist Christopher Cook speaks for many when he identifies mystical experience as something valuable and life enhancing to the individual that has indirect benefits to the wider community[29]. The professional community

[29] Chris C. H. Cook, „Psychiatry and mysticism".

of mental health clinicians needs those benefits badly, and a greater focus on love within the context of the clinical care would seem to point in that direction.