Could some forms of psychological adversity be a blessing in disguise?

Dr Noel D. Maturlu,

Abstract

Spirituality has been described as an ambivalent experience. On the one hand, due to its soothing affective potential, spirituality has been lauded by medical science as the most protective factor against depression and other mental disorders. On the other hand, however, spirituality can lead to spiritual emergencies and other mental disorders. This paper provides scientific explanation to the ambivalent nature of spirituality and why spiritual emergencies and other mental disorders can be a blessing in disguise as they can significantly increase the possibility of spiritual growth and a more robust mental wellbeing. Implications for mental health practice is also discussed.

Key words: *Spirituality, spiritual emergency, mental health, mental disorder.*

Spirituality has long been associated with an intensified sense of calm, positive self-worth, love, connectedness, and general life satisfaction (Kor , Pirutinsky, Mikulincer, Shoshani, & Miller, 2019). Due to its soothing potential spirituality has been lauded as the most protective factor against depression "known to medical or social sciences" (Miller, 2013, p.333). In their ten year longitudinal study, Miller, et al., (2012) found that spirituality was correlated with a 90% decreased risk of developing the major depressive disorder (MDD) in adults in high familiar risk band.

However, the psychological benefits of spirituality have been described as paradoxical because they often emerge from somewhat ambivalent experiences. For example, Granqvist and Kirkpatrick (2004) found that approximately 80% of major spiritual experiences are preceded by some form of psychological distress, commonly known as "spiritual emergency" (Grof & Grof, 2017). Furthermore, Harris, Ellor, and Yancey, (2017) linked 1 in 6 of mental illness to spirituality, and Fingelkurts and Fingelkurts, (2009) found schizophrenic hallucinations and delusions had religious and spiritual context. Findings such as these have led to inclusion of Religious or Spiritual Problem in the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (American Psychiatric Association, 2013; cf Turner , Lukoff, Barnhouse, & Lu, 1995). Conversely, many, including psychologists, view spirituality as a form of psychosis rather than a potential

therapeutic intervention (Lukoff , Lu, & Turner, 1998). Thus, psychiatrists' view that spirituality is pathological rather than strength has contributed to strained relationships between psychiatric care and spiritually inclined patients, with the latter often perceiving mental health professionals as unsupportive, incongruent, and even a hindrance to their spiritual growth (Breuninger , Dolan, Padilla, & Stanford, 2014).
The aims of this paper, therefore, are twofold. Firstly, to establish the link between spirituality and psychological distress, and secondly, to understand what role, if any, spirituality, spiritual emergencies and other forms of psychological distress have in enhancing positive mental health outcomes.

Before proceeding further, there are key terms that need to be defined. First, the term spirituality is used to mean a reverential, personal relationship with the Superior Power referred to in theistic traditions as God, Jesus Christ, Yahweh, Allah, Buddha, and so on (e.g. Granqvist & Kirkpatrick, 2013; Miller , 2013). For convenience, the term “God” is used in this paper to represent Superior Power. Secondly, spiritual experience, as alluded to earlier, is a subjective encounter that is experienced within the context of spirituality. Lastly, “spiritual emergency” is used to mean clinical and non-clinical psychological distress associated with a spiritual experience (Grof & Grof, 2017).

Although other studies and literature are cited when necessary, this brief essay is hinged on two major papers namely, Taylor, (2005) which is a systematic review of key findings on “the sources of higher states of consciousness” and Miller et al., (2014) - a longitudinal study that involved the second- or third-generation offspring of high familial risk of depression and the first generation of low familiar risk. In Miller’s study, anatomical magnetic resonance images of the brain were measured 2-time points during 5 years, to determine whether there were differences in cortical thickness that correlated with spiritual importance. A critical appraisal done by using a mixed method appraisal tool (Hong , et al., 2018) showed both papers to be scientifically sound. Authored by respected psychologists, Taylor, (2005) and Miller et al., (2014) are peer-reviewed papers published in respected journals. However, Taylor, (2005)’s guideline that determined the inclusion and exclusion criteria or sources was not clear, and the psychometric information of instruments was not provided. Despite these limitations, the paper was deemed to contain relevant information for this study.

Although not all spiritual experiences can lead to psychopathological outcomes, spirituality can lead to psychotic disorders (Taylor, 2005). Explaining the possible reasons behind this phenomenon, Taylor argued that spirituality operates in a higher state of consciousness that demands “intensive consciousness-energy” (a homeostatic power that facilitates healthy existence and interactions with the world around us. This includes the regulation of mental

processes such as perception, attention, thinking, memory, planning, and problem-solving). Thus, spiritual experiences – particularly those that lead to profound transformation – can cause dramatic disruption of homeostasis, the process that in turn helps to release intense positive psycho-mystic energy (some scholars have correlated this psycho-mystic energy with prefrontal cortex gamma brainwaves - the brain's optimal frequency associated with intensified consciousness and heightened sense of soothing affections of oneness, love, and compassion; e.g. Buzsaki, 2006; Lutz, Greischar, Rawlings, Ricard, & Davidson, 2004; Rubik , 2011). Taylor also suggests that the sensory inputs generated by the spiritual experience can be too powerful for the existing cognitive structure causing it to be immobilized. Thus, individuals undergoing spiritual emergency experience psychological turmoil because their brain – the same cognitive faculties involved in perception , logic , problem solving and decision making - is either engaged in psycho-mystical experience or undergoing reorganization (see also Cozolino, 2014; Cross, 2007;Menezes & Moreira-Almeida, 2010).

Furthermore, intensified consciousness afforded by spiritual emergency can cause individuals to see and / or hear things that are alien to themselves or other people around them (Taylor 2005). To the protagonists or those unfamiliar with spiritual emergencies, these experiences can easily be confused with positive psychotic symptoms such as hallucinations or delusions (Lukoff, et al., 1998).

Apart from having the potential to cause psychological distress spirituality has even greater therapeutic and protective ability against other forms of psychopathology such as depression. In their study, Miller et al. (2014) found adults who reported high importance of spirituality – independent of familial risk of depression - had thicker cortices in the left and right parietal and occipital regions, the mesial frontal lobe of the right hemisphere, and the cuneus and precuneus in the left hemisphere. Further results also indicated that the effects of strong spirituality were significantly pronounced in the high-risk group than in the lower risk group, especially in the mesial wall of the left hemisphere (areas that have generally been correlated with self-awareness and consciousness in relation with others; Lou, et al., 2004; Vogt, & Laureys, 2005) the areas that are also significantly associated with a familial risk of developing major depressive disorder (MDD). Miller found also that parietal cortical thickness was inversely correlated with MDD symptoms severity in the high-risk group more significantly than in the low-risk group. This finding suggested that thicker cortices in these areas offered proportionate protection against MDD symptoms, presumably by increasing sensitivity and conductivity of soothing divine affection and expansion of a cortical reserve that to some degree counters the vulnerability for developing familial MDD posed by cortical thinning. Miller's findings are in congruence with other studies that indicate spirituality provides greater protection against both the onset and

recurrence of mental disorders such as depression, alcohol and drug abuse (e.g. Miller, 2013; Peterson et al., 2009).

Empirical evidence exists that indicates neurological distress, just like a muscle tear that offers greater possibility of building muscle mass, could offer greater possibility of building a more robust mental resilience. According to Dr. Michael Karns, we build muscle mass from the microtears we sustain from exercise. Once the muscle tear occurs "the body sends good nutrition and good blood to the area to heal. This, in turn, is how you grow musculature. You have to break muscle down to build it back up stronger" Karns, (2018, pg6). In essence, it takes a torn muscle, a good supply of nutrition, and time to build a stronger muscle. Similarly, it takes mental breakdown to rebuild even a more robust mental health. For example, further analysis by Miller et al., (2014) found that thinning of cortices - which is translated as a high-risk factor of MDD - and the previous episode of depressive illness were contributing factors of a more substantial increase of cortical thickening in individuals who reported spirituality to be important to them. These findings seem to suggest that mental structures might need to be broken down to build it back up stronger. Miller posted that their study suggested a depressed mind, a good supply of God's love, and healing time contributed in building a more resilient mind. Thus, mental breakdown was suggested to be an added advantage in building stronger mental resilience than it is a risk, hence, Miller's assertion that,

"the large magnitude and spatially extensive degree of thinning ... in the [high risk] group may have afforded a larger potential effect of religiosity on cortical thickness than in the [low risk] group, where ceiling effects presumably constrained to some extent the morphologic effects of religiosity" (Miller, et al., 2012, p. 133).

Like in the "microtear" effect of the muscles that build stronger muscles, Miller's study seems to suggest that neurological depression associated with the thinning and probably the rupture of cortices breaks the ceiling effects that affords even greater potential for thicker cortices. Thus, it takes a depressed mind (cortices), a good supply of love, and time to build a more resilient mind. Interestingly, Miller found that the cortices on the right hemisphere (regions correlated with spiritual sensitivity, perception, and navigation; Davis, Moriarty, & Mauch, 2013; Kjaer, Nowak, & Lou, 2002) were substantially thinner than the mirror left regions, which suggests that psychological distress opens a spiritual "door" in the right brain through which God's presence (which is characterised with positive affections of oneness, joy, hope, compassion, and love; Cross, 2007; Bible, John 14:27; Taylor, 2020) can be experienced, and used to build more robust protective cortices on the left brain. This evidence warranted Miller's assertion that psychological turmoil and spiritual growth are "two sides of the same coin" (Miller, 2013, p. 340).

Conclusion

Spiritual emergencies, ambivalent as they might be, can be described as inherently beneficial transitory, short-lived and under proper therapeutic intervention do not lead into serious pathological outcomes (e.g. Cozolino, 2014; Menezes & Moreira-Almeida, 2010). New state of consciousness that emerges from spiritual experiences demands time and space to gradually integrate new knowledge (schema) into an upgraded homeostatic equilibrium, bringing the possibility of even greater psycho-spiritual growth (Cross, 2007; Miller, et al., 2012; Miller, et al., 2014). Thus, individuals undergoing spiritual emergency should be given therapeutic support and education to help normalize and integrate their new spiritual experiences.

Moreover, some forms of psychological disorders, regardless of their causes, can be a blessing in disguise as they can significantly contribute in building a more robust mental health. Thus, some forms of psychosis should be approached as "birth ping" - a painful but necessary process that opens the possibility of even greater psycho-spiritual growth (Lukoff, et al., 1998). Lastly, spirituality has theoretical and empirical framework for being the most effective intervention for mental disorders, and if appropriately applied and integrated into the mental health care system spiritual experiences can play a significant role in enhancing mental well-being.

References

Association, A. P. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*: American Psychiatric Pub.

Breuninger, M., Dolan, S. L., Padilla, J. I., & Stanford, M. S. (2014). Psychologists and clergy working together: A collaborative treatment approach for religious clients. *Journal of Spirituality in Mental Health, 16*(3), 149-170.

Cozolino, L. (2014). *The neuroscience of human relationships: Attachment and the developing social brain (Norton series on interpersonal neurobiology)*: WW Norton & Company.

Fingelkurts, A. A., & Fingelkurts, A. A. (2009). Is our brain hardwired to produce God, or is our brain hardwired to perceive God? A systematic review on the role of the brain in mediating religious experience. *Cognitive Processing, 10*(4), 293-326.

Granqvist, P., & Kirkpatrick, L. A. (2004). " Religious Conversion and Perceived Childhood Attachment: A Meta-Analysis". *The International Journal for the Psychology of Religion, 14*(4), 223-250.

Granqvist, P., & Kirkpatrick, L. A. (2013). Religion, spirituality, and attachment.

Grof, C., & Grof, S. (2017). Spiritual emergency: The understanding and treatment of transpersonal crises. *International Journal of Transpersonal Studies, 36*(2), 5.

Harris, H., Ellor, J. W., & Yancey, G. (2017). DSM-5: The intersectionality of spirituality, culture, and aging. *Journal of Religion, Spirituality & Aging, 29*(1), 3-17. doi:10.1080/15528030.2016.1243502

Hong, Q. N., Pluye, P., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., . . . Nicolau, B. (2018). Mixed methods appraisal tool (MMAT), version 2018. *Registration of copyright, 1148552*.

Kor, A., Pirutinsky, S., Mikulincer, M., Shoshani, A., & Miller, L. (2019). A longitudinal study of spirituality, character strengths, subjective well-being, and prosociality in middle school adolescents. *Frontiers in psychology, 10*, 377.

Lukoff, D., Lu, F., & Turner, R. (1998). From spiritual emergency to spiritual problem: The transpersonal roots of the new DSM-IV category. *Journal of Humanistic Psychology, 38*(2), 21-50.

Menezes, A., & Moreira-Almeida, A. (2010). Religion, spirituality, and psychosis. *Current psychiatry reports, 12*(3), 174-179.

Miller, L. (2013). Spiritual awakening and depression in adolescents: A unified pathway or “two sides of the same coin”. *Bulletin of the Menninger Clinic, 77*(4), 332-348.

Miller, L., Wickramaratne, P., Gameroff, M. J., Sage, M., Tenke, C. E., & Weissman, M. M. (2012). Religiosity and major depression in adults at high risk: a ten-year prospective study. *American Journal of Psychiatry, 169*(1), 89-94.

Turner, R. P., Lukoff, D., Barnhouse, R. T., & Lu, F. G. (1995). A culturally sensitive diagnostic category in the DSM-IV. *The Journal of nervous and mental disease, 183*(7), 435-444.