Lack of Spiritual Practice - an important risk factor for suffering from distress

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Introduction

In recent years, the relationship between spirituality and health has become a new topic of interest within clinical and health sciences alike (Culliford, 2002; Miller & Thoresen, 2003). Empirical findings have identified both religiosity and spirituality in the generic sense as a potential health resource (Koenig, McCullough, & Larson, 2001; Larson, Swyers, & McCullough, 1998; McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000; Seeman, Dubin, & Seeman, 2003). There is, however, still considerable ambiguity in research findings and correspondingly uncertainty about the mechanisms that drive the spirituality–health connection and research in this area is beset with specific conceptual and methodological problems.

1. There is first and foremost considerable uncertainty about basic definitions. Not only do clear and universally accepted criteria for defining spirituality not as yet exist, there is also lack of clarity with regard to differentiating spirituality from other related constructs such as religion, religiosity, sense of coherence, purpose or meaningfulness, to name but a few. In particular, the terms ‘spirituality’ and ‘religion’ have been used interchangeably in a rather naïve way in past research endeavours. Although the two categories certainly have some common ground, there are important differences on closer inspection. For example, an individual may develop spiritual faith in a higher being, ultimate power or transcendental principle whilst not necessarily being aligned to any form of orthodox religion. On the other hand, an individual may also develop a deep-rooted spiritual conviction that tenets of an established creed are true, but personally never have experienced any sense of a divine or transcendental component. Thus, identifying precise criteria that are suitable for demarcating spirituality from religion is far from easy, as both are complex and multi-dimensional constructs that are not only difficult to grasp but also non-exclusively related to each other. However, there is an aspect that might give at least a heuristic basis for their differentiation: whereas spirituality points to the subjective, experiential and private dimensions of transcendence, religion refers to objective and social dimensions, which offer a cultural framework for the interpretation of spirituality. In other words, religious traditions may be interpreted as cultural venues that help codify, structure and interpret spiritual experiences by means of providing explanatory models that are culturally accepted.

2. Thus, as spirituality is a complex, interconnected and also culture-dependent phenomenon with many facets, it may not only be understood in many ways but also on many levels. Although the holistic nature of spirituality has to be taken into account in order to do justice to the fragile phenomenon in question, for a proper scientific analysis of distinct pathways pointing from spirituality to health, different aspects – such as

spiritual practices, attitudes and experiences - have to be differentiated. Nevertheless, as the very essence of spirituality is, strictly speaking, a subjective phenomenon that must be embedded in an individual life context, methodological problems are naturally entailed in this reductionist approach. To put it bluntly, spirituality as an essentially subjective phenomenon defies experimental manipulation and objectification. This may be the reason why there are problems associated with researching spirituality by means of experimental approaches such as randomized controlled trials and may explain why research has predominantly focused on observational studies so far. It is hardly surprising that investigations of the relationship between spirituality and health have been repeatedly criticized for failure to control for important confounders and lack of longitudinal studies (Miller & Thoresen, 2003; Powell, Shahabi, & Thoresen, 2003).

Pathways from Spirituality to Health

Although in the past it has frequently been hypothesized that it is mainly the element of social coherence associated with religious practice that conveys the health benefits (Levin, Chatters, Ellison, & Taylor, 1996; Powell et al., 2003), new conceptualizations suggest that it is spiritual experience and its intrapersonal effects as moderated by regular spiritual practice rather than belief sets, attitudes or behaviour alone that may be pivotal to understanding the pathways from spirituality (George, Larson, Koenig, & McCullough, 2000).

1. Spiritual or mystical experiences as they are reported in the mystical traditions are presumably at the roots of most forms of religions.

2. As indicated by the plethora of conversion phenomena reported in the course of human history, spiritual experiences seem to be able to exhibit major impact on human beings.

3. Spiritual practices like prayer, meditation or different forms of contemplation may be seen as intended and designed to elicit spiritual experiences (Meraviglia, 1999). It has additionally been shown that regular spiritual and meditative practice entails not only a characteristic change in the way the self is perceived and organized but also alters physiological parameters (Davidson et al., 2003). For example, a recent FMRI-study has found evidence that individuals practicing some form of mindfulness meditation seem to be able to alter their personal psychological model so they can dissociate their self awareness of the present from their long term ‘self image’ (Farb et al., 2007). Thus, there is good reason to assume that the effects cannot be merely explained as consequences of interpersonal or social factors and that to completely elucidate them one has also to take intrapersonal factors into account.

The phenomenology of spiritual experiences

It should be noted that the phenomenology of spiritual experiences do not necessarily support the popular assumption that the relationship between spirituality and health is mainly positive. To begin with, spiritual experiences are not always positive in nature, but often associated with crises (Wardell & Engebretson, 2006) and, further, the phenomenological similarity of transcendent and psychotic states is well known (Lukoff, 1988; Thalbourne, 1991). This may be why, for example, spiritual experiences have been interpreted as acts of ego regression, borderline psychosis or psychotic episode and have been associated with temporal lobe dysfunction (Lukoff, Lu, & Turner, 1992).

The authors' research

We started from the assumption, first declared within academic psychology by William James a century ago, that spiritual experiences can be a major pathway from spirituality to health (James, 1904). In his important treatise that comprised his edited Gifford Lectures on 'Natural Theology', James distinguished two types of spiritual health, the *healthy minded* and the *sick soul*. Whereas the spirituality of healthy-minded individuals leads to a positive outlook on life, sick souls tend to be depressed and have an anxious outlook on life; according to James, the only remedy for them is a powerful mystical experience.

We would agree with James that there may be both positive and negative influences of the spiritual domain on health, because stabilizing spiritual experiences may foster health while, in a parallel manner, destabilizing spiritual experiences may enhance distress. The interpretation of spiritual experiences as potentially stabilizing or destabilizing may be associated with the individual belief system. For example, the spiritual experience of universal connectedness can be experienced both as utter dread of ego dissolution or as gratifying experience of ego expansion, depending on the individual's system of reference. Here, the question immediately arises as to how a negative spiritual experience might be differentiated from a psychopathological experience?

In order to be able to investigate the prevalence and cognitive evaluation of positive and negative spiritual experiences, we have developed, pilot-tested, cross-validated and revised a 25-item instrument called *Exceptional Experiences Questionnaire (EEQ)* (Kohls, 2004; Kohls, Hack, & Walach, 2008, in print; Kohls & Walach, 2006).

Summary of Research

The Exceptional Experiences Questionnaire (EEQ)

Detailed information on development and validity of the EEQ has been published elsewhere (Kohls, 2004; Kohls et al., 2008, in print; Kohls & Walach, 2006). In short, the EEQ was developed because existing instruments embracing spiritual experiences such as the Daily Spiritual Experiences Scale

(Underwood, 2006; Underwood & Teresi, 2002) have been designed as unidimensional constructs, which only assess positive spiritual experiences. In contrast, the EEQ captures diverse positive and negative spiritual, exceptional and psychopathological experiences by asking about the frequency of those experiences as well as their current evaluation as additional information. The EEQ shows adequate discriminant validity with sense of coherence, social support and mental distress and convergent validity with transpersonal trust. Specifically employing a principal component factor analysis, we were able to show that exceptional experiences are phenomenologically distinct: examples included 'I am illumined by divine light and divine strength' and 'a higher being protects or helps me' (factor 1 'positive spiritual experiences'); 'my world-view is falling apart' and 'a feeling of ignorance or not knowing overwhelms me (factor 2 'experiences of ego loss and deconstruction'); 'I clearly hear voices, which scold me and make fun of me, without any physical causation' and 'I am controlled by strange and alien forces (factor 3 'psychopathological experiences and delusions') and 'I dream so vividly that my dreams reverberate while I am awake' (factor 4 'visionary dream experiences'). There exists a 57-item long version, which mainly serves as a phenomenological research tool and a 25-item short form, which shows good psychometric properties (Cronbach's alpha: r = .89, test – retest reliability after 6 months r = .85). It is noteworthy that we have cross-validated the EEQ with post-questionnaire interview data in order to test for the reactivity of the instrument (Kohls et al., 2008, in print).

Summary of Research Findings

We have investigated the EEQ in non-clinical and clinical populations alike (Kohls, 2004; Kohls & Walach, 2006, 2007; Kohls, Walach, & Wirtz, 2008, accepted for publication). Particularly, intersample differences between spiritually practicing and non-practicing individuals have been compared. In short, the five most important results for clinical practice were as follows:

1. With regard to the prevalence of exceptional experiences, we have been able to show that individuals with regular spiritual practice report both more positive spiritual experiences, experiences of ego loss as well as visionary dream experiences. In contrast, no differences were found for psychopathological experiences.

2. With regard to the cognitive assessment of exceptional experiences, we have shown that spiritually-practicing individuals evaluate both experiences of ego loss and visionary dream experiences more positively. In a parallel manner to the prevalence data, no differences between the cognitive evaluations of psychopathological experiences were found.

3. A comparison of the impact of exceptional experiences of spiritually practicing and non-practicing individuals by means of a linear regression analysis revealed different pathways from experiences of ego loss to psychological distress (Kohls & Walach, 2007). Although spiritually practicing individuals reported more exceptional and spiritual

experiences, they accounted only for 7% of psychological distress (as measured with the Brief-Symptom-Inventory (BSI)) in the spiritually-practicing sample, but for 36% of distress in individuals with lack of spiritual practice. Further analysis revealed that experiences of ego loss had no effect on psychological distress in the group of spiritually practicing individuals, while they exhibited significant impact on distress in individuals with lack of spiritual practice. In contrast, positive spiritual experiences had no large buffering impact on distress. Based on these findings, we have suggested that spiritual practice could be considered to be a specific coping strategy for the distress caused by experiences of ego loss. It is noteworthy that a more sophisticated re-analysis of the data by means of structural equation modelling has corroborated this finding (Kohls et al., 2008, accepted for publication).

4. We have replicated the differences in pathways from exceptional experiences to distress in a sample of N = 111 patients with chronic illness (chronic fatigue, migraine, irritable bowel) that were treated in a single integrated medical practice (Kohls, Walach, & Lewith, 2008, submitted). Employing linear regression analysis, we were able to show that mindfulness acted not only as a generic buffer against distress, but particularly as a buffer against distress derived from experiences of ego loss. We have therefore proposed that lack of mindfulness may be regarded as a distinct risk factor for populations that are prone to experiencing experiences of ego loss, such as chronically ill patients.

5. We have also compared the test-retest reliability after 6 months for psychological distress as measured with the Brief Symptom Inventory (a 53 item short form of the Symptom-Check-List-90) between two subsamples of spiritually practicing and non-practicing individuals, which were post-hoc matched for important sociodemographic parameters (Kohls & Walach, 2008, accepted for publication). The test-retest reliability after sixth month was r =.62 for the spiritually practicing individuals and r = .78 for the sample with lack of spiritual practice, indicating a statistically significant difference Thus, individuals engaged in spiritual practice(s) seem to perceive distress as temporary states rather than permanent traits.

Conclusions

In summary, our research findings point to the fact that spiritual experiences are of major importance to health. In the light of our findings, the following points seem to be important from a clinical perspective:

1. Regular spiritual practice seems to be able to endow an individual with an important resource for resilience against destabilizing experiences. Thus, from a clinical perspective, instead of promoting positive spiritual experiences as a venue for promoting health, one should rather focus on the potential for augmented distress in individuals with lack of spiritual practice stemming from experiences of ego loss. To put it bluntly, lack of spiritual practice may potentially

be regarded as a distinct risk factor, particularly for individuals that are prone to experiencing experiences of ego loss.

2. Spiritual experiences and particularly destabilizing experiences should by no means be lumped together with psychopathological experiences by the clinical practitioner and the diagnostician alike. We believe that pathological interpretations of (temporarily) destabilizing spiritual experiences are frequently erroneously made due to the fact that spiritual and psychopathological experiences have not been yet disentangled in a satisfying manner. It follows that finding suitable criteria for differentiating spiritual experiences from psychopathological symptoms is an important topic for the advancement of the psychiatric profession.

3. Based on our findings, one might be inclined to recommend regular spiritual training as a preventive method for buffering distress. While we would in principle agree with this statement, we would like to address some caveats here. It is important to recall that spiritual practice apparently increases both the frequency of positive and negative spiritual experiences. Thus, establishing a routine of spiritual training may at first potentially induce distress, which could potentially add to the extant distress. Additionally, spiritual competences cannot be established in a short period of time but are rather long-term goals. Thus, in order to benefit from distress-annihilating effects of regular spiritual practice, it needs strictly speaking to be understood as a preventive rather than curative intervention.

4. As regular spiritual practice may exhibit major impact on stress perception and coping alike, it seems to be important to gather information about the spiritual history of a patient, thereby particularly paying attention to regular introspective, contemplative and meditative training. Moreover, as we have found significant differences between the time stability of distress between spiritually practicing and non-practicing individuals, this is a strong argument against the employment of distress scales as single criterion for assessing the effects of pain in spiritually practicing individuals.

To sum up, we believe that our findings point to a blind spot within psychiatric lore that needs to be closed. With the rise of modern medicine, spiritual approaches to coping with and understanding distress have been largely abandoned, perhaps with the exception of psycho-oncology and the nursing of terminally ill patients (Georgesen & Dungan, 1996; Smucker, 1996). Instead, distress has been defined by mainstream conceptualisations as a negative phenomenon, consisting of a physical and a psychological component only. It is our firm belief that psychiatry and clinical psychology would make greater progress if mental health professionals dared to widen their concepts to include spiritual aspects.

Further Research

We are currently trying to collect data from clinical and non-clinical populations in Hungary, Germany, Great Britain and the United States. Should you be interested in collaborating with us, please feel free to contact either Professor Dr. Dr. Harald Walach (harald.walach@northampton.ac.uk) or Dr. Niko Kohls (kohls@grp.hwz.uni-muenchen.de).

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