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Spiritual Sickness: A New Perspective and Approach to the Treatment of Psychosis

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Introduction

Spiritual Sickness

Man's attempt to understand and classify phenomenological experiences that cross the boundaries of the general consensus of what constitutes normalcy has produced varying perspectives on what these experiences mean and how to work with them. Modern "civilized" man classifies these experiences as stemming primarily from biological and or psychological deficiency, while societies that embrace more "archaic" modes of classification interpret these episodes as being indicative of transformation and utilize the experience as a liminal space for not only healing but for transfiguration.

Unlike modern psychiatry's view on psychoticism as a condition with little to no recourse other than symptom management, societies with shamanistic spiritual beliefs rather equate a psychotic break to a fever, signaling not illness as an end-all but rather the beginning of a process, essentially spiritual growing pains. In fact, many cultures do not view this process as a "sickness" in the Western sense of the word, but rather an unpleasant condition forcing one to have to face an unsettling truth. "At first he is apparently robust, but in the process of time, he begins to be delicate, not having any real disease but being really delicate. He dreams of many things and his body is muddled and he becomes a 'house of dreams"' (Calloway, 1868, p. 260).

Rather than viewing this process as leading to the finality of being lost to the depths of the unconscious, the shaman recognizes that the psychotic break is a platform for resolving re-

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pressed or unaddressed issues. Many of these concerns revolve around relational issues with other family or community members (this can stem from several different areas including trauma, grief, or guilt revolving around negligence of ancestral rituals). "Becoming a diviner is not only an entrepreneurial means of earning a living but also a means of resolving interpersonal problems in the family" (Hirst, 2005, p. 7). Because of cultural norms and rules, it is not always acceptable for these complaints to be made openly. In these cases, psychosis provides a culturally acceptable way of airing out grievances, to those whose voice has otherwise been muffled.

It is believed with the proper ritual cleansings a person will not only be cured but will come out of the experience as a shaman themselves. Here rather than pity the patient and outcast them from the community, the patient is elevated to a venerated figure within the community. It can be argued along lines similar to Hammond-Tooke who theorized that Nguni diviners were subject to the ukuthwasa affliction, resulting in their emergence as duly recognized and empowered psychic sensitives with powers of intuition that are routinely and recursively employed in divination and healing. (Hirst, 2005, p.7). This transformation of the patient to a healer is similar to the Jungian idea of the wounded healer. The shaman's approach is congruent with psychodynamic theory, which asserts that strong feelings and emotions that are not dealt with consciously are repressed into the unconscious where they return to terrorize as inner demons.

Symptomatology of Spiritual Sickness VS Psychosis

The key features that define psychotic disorders per the DSM-5 are delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms. These same features can be found in a person undergoing an episode of spiritual sickness. Much like the medical model's symptomatology of psychosis, spiritual sickness shares several of the same characteristics. Common symptoms include visions, vivid dreams, headaches, and somatic complaints (Kalweit, 1988, 2000, & Turner, 1992).

Precipitating Factors

Trauma appears to be a consistent precipitating event in both spiritual sickness and DSM-5 schizophrenic spectrum disorders and mood disorders featuring psychotic features (Lataster, Myin-Germeys, Lieb, Wittchen & Van Os, 2011; Steel, Fowler & Holmes, 2005). Events leading to spiritual emergencies can range from relatively mild experiences such as rejection from a romantic partner (Hirst, 2005, p. 9) to more extreme events such as witnessing the

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death of several family members (Hirst, 2005, p. 9). Other instances of emotionally upsetting events revolve around taboos specific to the culture. These taboo violations often hit hardest the people who have the least power in the community. For example in the case of "Ms. G", a 45-year-old married Xhosa woman who developed psychotic symptoms after discovering her husband was having extramarital affairs (Hirst, Cook & Kahn, 1996, p. 271-272). Another instance is the case of a Ndembu woman who developed the *Ihamba* condition (a form of spiritual sickness where a person believes a human tooth is traveling through their body causing psychological and somatic pains). The Ihamba ritual covered by Edith Turner in 1985, describes how the condition develops as a result of pent-up feelings of resentment towards family members. In fact, an integral stage of the healing process is called *mazu,* which can be translated as "*words",* or the "coming out with the grudges" (Turner, 1985, p. 66).The latter two cases present subjects whose protest to their experience would not normally be tolerated outside of this context of being "mad."

Utilization of Pathological Defense Mechanisms

Psychiatrist George E. Vaillant created a 4-tier hierarchy of defense mechanisms ranging from pathological to mature defenses (Vaillant, 1994). From a psychodynamic perspective, a person in the throes of a psychotic episode would be most likely functioning between Level 1 and 2, pathological and immature defense mechanisms respectively. Level 1 (the least adaptive of the hierarchy) consists of psychotic denial and delusional projection. Psychotic denial can be seen in cases of repressed trauma. Often times the person experiencing the onset of a psychotic episode does not appear to acknowledge the precipitating factor that has to lead to the psychic upheaval. When a patient comes in to seek treatment for spiritual sickness, rarely will they report having experienced a recent trauma or upsetting life event. Rather they focus on reporting the externalizing symptoms, whether they are bodily pains, sleep disturbances, or hallucinations. This perception of externalizing feelings into physiological symptoms can be seen as delusional projection. For example, the 45-year-old Xhosa woman mentioned previously (Hirst et al., 1996, p. 271-272), developed a delusion of having worms in her vagina after discovering her husband had been unfaithful. When seeking treatment, she did not initially report the factors leading to this condition, but rather sought medical assistance for a perceived bodily disturbance. Interestingly enough, the sexual nature of her delusion masked the true feelings of disgust and shame revolving around her husband's infidelity. Although the symptoms themselves are a delusion, they are highly symbolic of the reality she was experiencing.

In addition to reporting the somatic sensation of worms in her vagina, she also reported

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being visited daily by a demon posing as her husband "commanding her to wash his clothes and clean the house." (Hirst et al., 1996, p. 272). The inability to voice her resentment at having to maintain her marital and domestic obligations to a man who was being unfaithful to her, lead her unconscious to project these sentiments as a "demon."

Shamanism's Approach to Treatment

The shaman does not view the patient's state of mind as being detached from reality, but rather as a reflection of an internal spiritual crisis requiring as much respect and acknowledgment as physiological illness. "If you bar the way to the Itongo (ancestral spirits that cause the spiritual sickness), you will be killing him. For he will not be an inyanga (diviner), neither will he be a man again; he will be delicate and become a fool and he will be unable to understand anything" (Calloway, 1868, p.261).

Shamanic intervention can be divided into 2 primary stages, including a 3rd optional stage. The first stage is diagnosis within the socio-cultural context. This first stage resembles a modern psychological intake. Rather than make a diagnosis using DSM-5 or ICD-10 criteria, the shaman takes into account family conflicts, recent trauma, or emotional upsets that have preceded the onset of symptoms. The shaman acts as a safe third party, capable of voicing the concerns the patient was unable to, due to social class.

It is during the 2nd stage of treatment, that clinicians and shamans diverge on different paths. Because Western medicine is primarily concerned with empirical treatments that can be concretely measured, clinicians focus on that which can be physically observed and measured; the brain. Research suggests that there is a physiological component to psychosis. However, what research has not been able to prove is whether this physiological deterioration is the result of psychological breakdown, or whether the physiological condition precedes psychological symptoms.

Rather than attempt to convince the patient that what he or she is experiencing is not true, the shaman accepts the patient's experience and begins to treat them within the context of their delusions or hallucinations. In the case of Mrs. G., the married Xhosa woman discussed earlier, rather than focus treatment with the use of antipsychotics, the shaman acknowledges the woman's concerns about her husband's infidelities and agrees with her that she has indeed been bewitched. The healer recognizes that the patient's delusions and hallucinations are "condensed expressions of her social conflicts" and as "increasingly desperate and unsuccessful attempts to resolve the social conflict of her domestic situation." (Hirst et al., 1996, p.273-274).

Treatment begins with the patient being removed from their domicile and isolated from

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the rest of the community. During this time the patient is washed with several herbs meant to cleanse the patient externally of any witchcraft. Afterward, the patient begins a special diet (which excludes heavy foods such as meat, milk alcohol, or tobacco) and begins to ingest "ubulawu" plants used to increase and clarify dreams. (Hirst, 2005, p.16; Sobiecki, 2012). From a clinical perspective, this ritualized process is similar to inpatient treatment of psychiatric patients; the primary difference is the context in which the patient is being treated. The use of ubulawu plants, and the subsequent "copious dreaming" (Hirst, 2005), that results from taking it, leads to bringing forth repressed unconscious content. The shaman acts, much the same as the psychoanalyst, pulling forth, interpreting, and helping the patient reincorporate these painful feelings and fragmented components back into the psyche.

A final but not necessary stage in the shaman's treatment is training the patient in becoming a healer themself. Having suffered and survived this experience, the patient is now viewed as a liminal being, which has been on both sides of "madness" essentially. The patient goes from invalid to an elevated position as a healer within the community. This again is not much different from the Jungian concept of the wounded healer. Many times those who are drawn to mental health professions are those who have suffered from their own bouts with mental health issues. This change in status and act of giving back to the community is healing in itself.

Transition from Pathological Defenses to Mature Defenses

As discussed earlier, psychotic patients begin by utilizing pathological defense mechanisms such as repression, somatization, projection, and dissociation. The shaman by means of ritual works to bring forth repressed content, while at the same time treating the patient's complaints of somatic symptoms, by washing the body with "magical" plants said to remove maladies. Finally, if inducted as a shaman themselves, the patient is provided with a new more mature defense mechanism "sublimation". The patient's predisposition towards "magical thinking" can be subverted into a culturally acceptable and productive use.

Spirituality as a Means to an End

The cases analyzed throughout this paper have been exclusively from African countries, however, these techniques can be adapted to any culture. For example, the third stage proposed in this paper has been documented with Israeli female survivors of trauma. These women were taught to practice the spiritual practice of "channeling" as means of treating dissociation, with relatively positive results in regards to the management of their PTSD symptoms. (Stolovy,

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Lev-Wiesel & Witzutum, 2014). Serious mental illness such as schizophrenia should not be taken lightly, however, it should be taken into consideration, that the current mode of treatment being provided to persons suffering from psychosis, is incomplete. Treating these disorders solely on the basis of biology and with the use of antipsychotics disregards the role of culture and the social context where these symptoms arise. Rather than viewing spirituality as a hindrance to science, it should be viewed as a means to an end. Incorporating the belief system of the patient, regardless of how bizarre, not only lowers the patient's defenses against the clinician but may also provide a fecund environment for healing.

Keywords: shamanism, psychodynamic, spirituality, multiculturalism, African, Jungian, ethnography, anthropocentrism

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