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“The Psych, The Soul, And The Wardrobe.”

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INTRODUCTION

The etymology of psychiatry is understood to originate from the Latin word *psychiatria*, meaning “healing of the soul”. This can be traced back to the Greek words *psyche*, meaning “soul”, and *iatreia*, meaning “healing”. This understanding of the term is reflected in the early modern development of psychiatry as a specialty, where psychiatrists were referred to as “soul doctors” (Bloch and Singh 1998). By the mid-19th century psychiatrists were known as “alienists” as the specialty deviated from its medical origins. Psychiatrists became concerned with physiological features, brain size, and pharmacological treatments, as various scientific approaches began to dominate (Bloch and Singh 1998).

As a spiritual care practitioner within a major mental health hospital, it has struck me as curious that, although psychiatrists are etymologically concerned with treatment of the soul, the biomedical paradigm within which psychiatrists have operated, since the late 19th and early 20th centuries, has led to a clinical context in which few psychiatrists today would view themselves as treating the soul. Spiritual care, in particular, is viewed as alien to their specialty and thus treated with suspicion. However, when one looks at medical anthropology of the first one thousand years of western medicine, the question arises as to whether soul-care, and indeed spiritual care, is in fact alien to the psychiatric domain.

And yet when we turn to the origins of western medicine, we find that for Greco-Roman medical theorists, the human person is constituted of body, mind, and soul. In the majority view, the relationship between the soul and body is sympathetic. Illnesses of the mind-soul affect the body, just as illnesses of the body can affect the mind-soul. It is for this reason that I begin this thesis by revisiting this body of thought. Further, as we will see, this early pre-Cartesian view of the human person is now increasingly being supported by recent neuroscientific and medical research, and the second part of the thesis will explore the idea that rediscovery of this approach can have holistic implications for contemporary clinical spiritual and pastoral care. My hypothesis is that a more holistic approach to psychotic episodes is one in which spiritual care becomes integral, as a result of a more holistic understanding of the human person.

This does not mean that ancient Greco-Roman medical theory and contemporary neuroscientific or psychiatric understanding are perfectly aligned. Both operate from different medical-theoretical bases, as will be explained. Where the two come closest to each other, however, is in the domain of psychotic episodes, where the contemporary definition maps to some degree against a number of mind-soul illnesses identified by the medical schools that emerged within the Greco-Roman world. Psychotic episodes are thus used as a focal point for exploring the above hypothesis.

This thesis is informed by the following overarching question: what are the potential implications of an early western medical view of the body-mind-soul relationship for the spiritual care of people experiencing psychotic episodes? In order to arrive at an answer to this question, this thesis will address two subsidiary questions:

1. How does Greco-Roman medicine understand psychotic episodes in relation to the body-mind-soul, and how does medical theory inform its therapeutic approach to the body-mind-soul in persons suffering psychotic episodes?
2. What does contemporary neuroscience reveal about the role of spiritual care (soul therapy) for persons suffering psychotic episodes, and what are the clinical implications to a biomedical model for the incorporation of holistic care in treatment?

The questions will be addressed via application of a meta-analysis methodology to a systematic review of recent scholarship on Greco-Roman medical theories of mental illness – with a focus on psychotic symptoms – and how the body-mind-soul are approached in its treatment. The medical theory discussed in the literature spans 500 BCE – 500 CE. The results of the systematic review will be brought into dialogue with a survey of recent literature on current neuroscience in relation to soul care.

Together the questions and methodology shape the structure of the thesis which is divided into four chapters. Chapter One will begin with an introduction into the history of the soul, including a variety of debates amongst ancient Greco-Roman physicians and philosophers regarding the location and functions of the soul. This will lead into an exploration of the supposed sympathetic relationship between the body and the soul. Lastly, ancient madness will be paralleled against modern-day psychosis, specifically examining the mental ailments of phrenitis, mania, and melancholia.

Chapter Two will explore the health and sickness of the soul and psychotic episodes in Greco-Roman medical theory. Several theoretical frameworks and treatment methods will be surveyed: natural medicine and philosophy; the approaches of the Pneumatists and Methodists, and how these ideas were appropriated by early Christianity, including of the late-antique preacher John Chrysostom.

Chapter Three will investigate current literature and research on neuroscience and soul care. This will begin with an exploration of the role and function of spirituality in mental health care. This is followed by an analysis of what neuroscience is now saying about the brain and spiritual practices, which will include examining a particular brain region: the anterior cingulate cortex. Finally, the role and function of the forgotten soul – the gut – will be briefly highlighted, with an invitation for modern biomedicine to consider a sympathetic relationship between body and soul.

Chapter Four will call attention to the clinical implications for contemporary care, in supporting a person suffering from psychotic episodes within a holistic framework. These implications will encompass how one understands and treats the soul from a neurobiological and physiological framework; and both explores and advocates for the inclusion of clinical spiritual and pastoral care practices in the holistic treatment of psychotic episodes.

CHAPTER 1 – Body-mind-soul, mental illness and psychotic episodes in Greco-Roman medical theory

In this chapter the state of research on early Greco-Roman medical theory on the soul, soul-body relationship, and madness will be presented in three parts. Firstly, to be surveyed will be the diversity of opinions amongst the ancient Greco-Roman philosophers and physicians regarding the function, location and substance of the soul. Secondly, the relationship between the body and the soul will be examined, including a review of the numerous substances roaming throughout the body – psychic pneuma, vital pneuma, blood and humours. Thirdly, the ancient concept of madness will be examined, inspecting the key mental illnesses of phrenitis, mania and melancholia. These shall then be paralleled with modern-day psychosis. Key scholarship surveyed throughout this chapter includes the scholarly works of Philip Van der Eijk, Philip Bosman, Orly Lewis, Glenda McDonald, Marke Ahonen, Brooke Holmes, Chiara Thumiger, and Peter Singer. These are all emerging leaders in this field who have deepened current understanding of ancient medical writers on mental illness and the soul.

A history of the soul

As far back as Homer, approximately 2nd half of the 8th century BCE, the soul was initially thought of as an entity isolated from the body; one which entered from the outside (Crivellato and Ribatti 2007; Van der Eijk 2016). The soul was characteristic of one's life, identity and sense of self; silent whilst one was alive, but it exited the human body at one's death. However, throughout the centuries that followed Homer, a more natural and organic view of the soul and its biological relationship with the human body began to emerge. The soul, or *psyche*, began to be understood as one's vitality, "the life force [responsible for] inspiring, informing and energising the organism", and as an invigorating entity in charge of one's "cognition, emotion and locomotion [and] rational thought, deliberation and decision" (Van der Eijk 2016, 16). According to the Hippocratic author of *On Regimen*,¹ one's soul is material, is

¹ The Hippocratic author of *On Regimen* is unknown. In Eastern thought, it was a customary sign of respect for students of the school of Hippocrates to attribute their scholarly work to the collection of the Hippocratic Corpus.

constituted of fire and water, can experience psychological ailments if those elements of fire and water were to fall out of balance, stays conscious whilst the body sleeps, and, has no fixed or particular location – it roams throughout the human body by means of “passages” or *poroi* (Van der Eijk 2005, 128; Lewis 2016).

Many of the ancient physicians and philosophers held the belief that the human body contained one soul with multiple constituents. Plato was credited with the notion of the *tripartite soul*, despite the idea resulting from earlier Pythagorean conjecture through the writings of Diogenes Laertius: “the human soul [is] a tripartite structure. The brain was the seat of the mind (*nōus*) and the rational faculty (*phrenes*), whilst the heart was the place of courage, bravery and audacity (*thymos*)” (Crivellato and Ribatti 2007, 331). Plato suggested that one’s sense of *reason* was located in their brain, one’s sense of *will* was located in their thorax, and one’s sense of *emotions* was located in their liver. The Stoics used the analogy of an octopus to represent the soul; each of the eight legs of an octopus being representative of thought, speech, reproduction, and the five senses (Van der Eijk 2016). Galen was later responsible for elaborating on Plato’s notion of the tripartite soul:

[T]he brain was the seat of the ‘rational soul,’ which directed intellectual and cognitive activity; the heart was the seat of the ‘appetitive soul’ responsible for emotions; and the liver or abdomen was the seat of the ‘nutritive’ or ‘desiring soul,’ on which nourishment, growth and reproduction depended (Lewis 2016, 32).

In addition to the different theories about how the structure of the soul was envisaged, debate also concerned the primary physical location of the soul. From the time of the 5th Century BCE, the three emerging theories regarding the primary seat of the soul were encephalocentrism, cardiocentrism and haematocentrism (Van der Eijk 2005, 124).

For the encephalocentists, the brain was considered the *hēgemonikon* and the organ responsible for cognitive faculties. This view was held by Plato, the Hippocratic author of *On the Sacred Disease*, Alcmaeon of Croton, the Pythagoreans, and Galen (Van der Eijk 2005, 125; Crivellato and Ribatti 2007, 329; Lewis 2016). Alcmaeon was believed to be the first, approximately 5th century BCE, to ascribe cognitive and sensory faculties to the brain. He believed this to be true as all sensory functions

would become disturbed if there were to be any damage or movement to occur to the brain. Consequently, Alcmaeon was also the first to be credited with the notion that the brain is the primary seat of the soul (Crivellato and Ribatti 2007); the Father of Encephalocentrism, if you will. Some Hippocratic authors took things one step further and believed that not only was the brain the primary seat of the soul, but it was also somewhat responsible for neurological diseases (Crivellato and Ribatti 2007). In fact, these same Hippocratic authors believed that “brain corruption” was the source of madness, which was ultimately impacted by one of the four bodily humours – bile. (Crivellato and Ribatti 2007, 330). Galen of Pergamon (2nd century CE) is perhaps the most well-known physician who adopted, and fought for, the encephalocentric position. For Galen, “the brain is the *hēgemonikon*, the ruling principle and the regent part of the body [and] the brain alone is responsible for sensation and voluntary motion, which both are the main attributes of the rational soul” (Crivellato and Ribatti 2007, 330).

For the cardiocentrists, the heart was considered the ruling organ responsible for cognitive faculties, and this view was held by Diocles of Carystus, the Hippocratic authors of *On the Heart* and *On Disease 2*, Aristotle, the Stoics, and Praxagoras of Cos (Van der Eijk 2005, 125; Crivellato and Ribatti 2007, 330; Lewis 2016). Many contemporaries of Aristotle supposed that he believed the primary soul was located in the heart (Crivellato and Ribatti 2007), in fact, one of his followers offered a supporting anecdote: when one introduces themselves, they place their hand on their centre – heart – instead of on their head (Lewis 2016). However, Aristotle also offered several contributions regarding the human brain; the potential identification of nerves, or *poroi*; the difference between the cerebellum and the cerebrum; and he identifies “the spinal cord as an extension of the brain” (Crivellato and Ribatti 2007, 332). However, for Aristotle, the heart is the body’s primary organ responsible for “the principle of life, the generator of body heat, the font of blood and the origin of vessels [consequently] it is the organ that develops first in the embryo” (Crivellato and Ribatti 2007, 331).

For the haematocentrists, the blood was considered the primary soul roaming throughout the body being responsible for cognitive faculties. This view was held by the Hippocratic authors of *On Breaths* and *On Disease 1*, and by Empedocles (Van der

Eijk 2005; Lewis 2016). Empedocles resisted the idea that the soul was attached to a particular bodily organ, and instead held the view that the psychic pneuma was the essence of the soul, which resided in the blood, and was responsible for carrying out the soul's functions (Van der Eijk 2005; Lewis 2016).

One of the dominant reasons why locating the primary seat of the soul became significant to ancient philosophers and physicians, was due to their desire to establish the accurate “diagnosis and treatment of psychosomatic disorders” (Van der Eijk 2005, 123). However, Caelius argued that the primary seat of the soul is uncertain, that it was a fruitless debate to speculate that the *mind* was the ruling principle, and that there was no empirical evidence supporting that the brain was the *hēgemonikon* (Van der Eijk 2005, 121; McDonald 2009, 123). Yet, one of the criticisms against Caelius was his conjecture that other prominent physicians, such as Aristotle and various Hippocratic authors, did in fact hold such strong opinions on the location of the primary seat of the soul. For instance, whilst many of Aristotle's contemporaries accredited him with identifying one's heart as the primary seat of the soul, Van der Eijk believes this to be an oversimplification of Aristotle's theories, which in fact “leave no room for [the] location of the highest psychic faculty” (Van der Eijk 2005, 122). Similarly, whilst many Hippocratic writers were believed to identify the brain as the *hēgemonikon*, the author of *On Regimen* holds a position where the soul's location within the body is actually unspecified; “he even appears to assume that the location may vary” (Van der Eijk 2005, 122). Even Galen, a passionate encephalocentrist, believed the psychic pneuma was the soul's representative, and the substance responsible for carrying out its functions. Thus, even “Galen did not attempt to localize the rational soul in a specific part of the brain” (Crivellato and Ribatti 2007, 334; Lewis 2016). Therefore, whilst it appears that Caelius rebukes various physicians for holding strong views on the location of the primary seat of the soul, it would also appear that his rebukes are in vain. As Van der Eijk has correctly identified, it is an oversimplification and misrepresentation to consider that many of the ancient Greco-Roman philosophers and physicians held inflexible and rigid views. In fact, Van der Eijk goes so far as to posit that ancient Greco-Roman philosophers and physicians did not fit neatly into either a materialist or a dualist approach (Van der Eijk 2005, 122-128). Murphy appears to agree by postulating that Plato's view of the human person is dualistic, whilst

Aristotle's account is less so (Murphy 2006, 9). For Plato, he believes several elements to be true regarding the human person: a human is essentially an immortal soul contained within a corporeal body, the human soul is multilateral (tripartite), and this multifaceted soul is structured in a hierarchical manner (Murphy 2006, 12). For Aristotle, the soul is also structured hierarchically, however it is not considered immortal. Whilst Aristotle holds that the soul is essentially what gives the body life, it is still a *form* subject to his hylomorphic principle, indicating that the soul ultimately perishes with the physical body at death. The only exception for Aristotle is the mind, or *nous*; that our rationality, or rational soul, is immaterial and endures beyond death (Murphy 2006, 13; Crivellato and Ribatti 2007, 331).

Whilst the competition among these early medical theorists for the primary seat of the soul continued to predominately concern whether it resided in either the brain or the heart, much less attention was given to the third location of the soul: the gut. In fact, the gut has such significance that one often finds themselves making decisions based on their *gut feeling* or *gut instinct*. However, current neuroscience has an emerging body of research which now indicates the importance of the gut, the reference to it being the "second brain", and the intimate and intricate relationship between the gut, the brain, and the health of the body overall (Mayer, E 2018). This will be discussed in greater detail at the end of Chapter Three.

A sympathetic body and soul: the psychic pneuma, vital pneuma, blood and humours

The primary substances the ancient Greco-Romans believed were roaming in one's body included the vital and psychic pneumas, the blood, and the four bodily humours (Van der Eijk 2005; Bosman 2009; Lewis 2016). If any or each of these substances were to be affected, it caused various affections within the human body. One such example are the mental afflictions one could experience in having their bodily substances impacted.

Galen was the physician to differentiate between the *natural* and the *psychic* outworking's within one's body, accrediting these functions "to a mysterious, intelligent substance called *pneuma*, 'breath' or 'spirit', which became the carrier of all life forces in the body" (Van der Eijk 2016, 17). Galen believed that when one breathes in air, it is transformed by and in the human body, fashioned into *pneuma*, and the *pneuma* performs the various functions of one's soul. More specifically: vital *pneuma* was

launched into the body through one's inhalation and travelled from one's "heart through the arteries"; psychic *pneuma* travelled from one's brain by way of the nerves; and the "psychic *pneuma* was a mixture of refined vital *pneuma* reaching the brain through arteries, and of respired air which entered the brain directly through the nose" (Lewis 2016; 46). According to Galen, the psychic *pneuma* was responsible for functions such as cognition, reasoning, decision-making, perception and voluntary movement, whilst the vital *pneuma* was responsible for what might be considered "automatic" functions; growth, pulsation, digestion and nutrition (Van der Eijk 2016, 17).

The blood, vital *pneuma* and psychic *pneuma* were not the only constituents roaming within one's body. Various "humours" existed – wet substances likewise roaming within one's body – but whose presence had little bearing on the soul's composition and physiology. In fact, what was central to the composition of one's soul were the body's fundamental "building-blocks": *visible* elements such as nerves, veins, arteries, skin, and so on; and *invisible* elements such as "fire, air, earth and water, or their qualitative counterparts hot, cold, dry and wet" (Lewis 2016, 46). However, despite the physical substance of the soul being indeterminate, it was still held that the state of one's soul was reliant upon the state of one's body and its respective constituents. Specifically, "the balance of the mixture of invisible elements (i.e. fire, water etc., or hot, wet, etc.), the condition of the visible elements (veins, bones, etc.) and the quality and unhindered flow of the *pneuma*" (Lewis 2016, 46).

Reading one's pulse was an avenue to diagnose mental illness; for Galen "the pulse loses its natural rhythms whenever the mind is disturbed [therefore] the body and, especially, its troubles have an impact on psychic and mental functions" (Holmes 2013, 147). Additionally, if one region of the body were to become sick, it may produce sickness in another region; the human body "is an integrated whole, rather than an agglomeration of parts" (Holmes 2013, 152). Due to Galen's extensive work with dissections and vivisections (Crivellato and Ribatti 2007; Lewis 2016) it was acknowledged that "an affection that arises in one part [of the human body] is transported to another" (Holmes 2013, 152). Therefore, Galen leant towards a "fundamentally physical understanding of the soul", which can be demonstrated through "diet and physical activity, via the mixture they produce in the body". Similarly, "emotional experiences – rage, worry, distress, weeping, resultant insomnia

– may negatively affect physical health” distorting the equilibrium by generating “excessive heat, cold, or dryness, just as the wrong diet or baths will” (Singer 2021, 158 - 161).

With this in mind, Thumiger cautions and motivates us:

[T]o understand body and mind [soul] as deeply integrated and interdependent [...] our mind [soul] is biologically grounded in our body and our physical activities. As a consequence, when it comes to mental pathology, the body cannot be taken as a mere instrument of the mind [soul] or a surface on which symptoms of mental suffering emerge (Thumiger 2017, 70).

Similarly, for Lewis, whatever affected the soul powerfully affected the healthy functioning of one’s body (Lewis 2016). Singer offers a more detailed account of sympathy, identifying three specific senses: the unity and relationship between the body and mind (soul); the idea of the “whole-body” being examined within medical discourse; and, a “one-with-the cosmos” relationship, recognising that “human beings are part of a larger whole, conceived in terms of our environment or of the cosmos in an even larger sense, in a way which is importantly relevant to health” (Singer 2021, 155).

There appears to be a growing body of contemporary literature on the ancient suggestive concept of sympathy. Van der Kolk is an example, believing there to be an intricate relationship between one’s brain and mind/soul; “what happens in one is registered in the other” (2014, 102). The significance of this assumed sympathetic relationship will be discussed in further detail in Chapters Three and Four.

The madness umbrella: mania, melancholia and phrenitis

In antiquity, the term “psychosis” did not exist. Instead, ancient Greco-Roman medicine and philosophy used the term *madness* or *insanity* to be representative of the various mental afflictions one may experience. These afflictions included, but were not limited to, epilepsy, delirium, despondency, mania, melancholia, and phrenitis. For the purpose and position of this thesis, modern-day psychosis will be paralleled with classical madness; more specifically, mania, melancholia, and phrenitis.

In today’s society, mental illness remains a provocative and contentious topic that some contend “is neither mental or an illness” (Dols 1984, 136). In modern medicine,

mental illness has proven problematic to define being “inextricably interwoven over the centuries with cultural, religious and educational views” (Cilliers and Retief 2009, 130). In fact, Van der Eijk believes that culture plays a crucial role in the complexity of how societies conceive of mental illness and disease (Van der Eijk 2005). Bosman highlights one area – the English language – where culture has had a significant impact on the terminology one adopts for madness: lunatic, crazy, insane, being “nuts” or “out of your mind”, being unstable, deranged, mentally disordered or disturbed, to name a few (Bosman 2009, 1).

Throughout antiquity, madness gained the attention by predominately falling into two categories: medical texts, and mythical and philosophical literature. Whilst the ancient literature presented a likeness and resemblance between the two, from 5th century BCE literary writings continued to attribute madness to divine or supernatural intervention, whilst medical texts sought organic or biological origins (Cilliers and Retief 2009, 130).

Bosman proposes that whilst many of the ancient Greco-Roman philosophers and physicians appeared consumed with the location of madness within one’s body, “their primary concerns were [also] with diagnosis, causes and treatment”, often identifying explanations that swung on a pendulum between supernatural and natural descriptions (Bosman 2009, 5-6). For example, the philosophical work of Plato and earlier Homeric writings, adopted the notion of “divine madness” where madness could be conceived as either a blessing for the wider society, or one’s punishment for blaspheming or displeasing the gods (Bosman 2009, 1). However, for numerous ancient Greco-Roman medical physicians, they sought to offer *natural* explanations for madness, as opposed to *supernatural* ones, which were classified into one of three categories: according to the bodily part affected, whether the illness was acute, or whether it was chronic (McDonald 2009, 124; Ahonen 2014, 10). Consequently, madness was representative of “impairment or loss of reason”, where the predominant afflictions believed to cause this “loss of reasoning” were phrenitis, melancholia and mania (McDonald 2009, 106).

What is noteworthy to be reminded of is how ancient philosophical and medical writers shared a similar conception of the interconnectedness of physical and mental illness:

[Authors did] not make a categorical distinction between ‘mind’ and ‘body’: all mental affections [were] presented as being of a physical nature and having a physical cause. And even those authors who [spoke] about ‘soul’ (psuchē) as distinct from the body [...] still conceive of the soul as something physical, whose workings and failings can be described in material terms – for example a particular blend of fire and water – and influenced by dietary measures (Van der Eijk 2005, 27).

With this in mind, Diocles of Carystus (4th century BCE) offered some exemplary theories, which are captured by Crivellato and Ribatti: “madness was ‘boiling of the blood in the heart’ whilst lethargy was ‘a chilling of the psychic pneuma about the heart and the brain and a freezing of the blood dwelling in the heart’ and melancholy was considered as a disorder arising ‘from thickening of black bile around the heart’” (Crivellato and Ribatti 2007, 332). Similarly, also captured by Crivellato and Ribatti, Praxagoras of Cos (mid-3rd century BCE) believed that “the cause of madness was to be found in ‘a swelling of the heart, to which thoughts belong’, and delirium (phrenitis) ‘is inflammation of the heart’, whose natural activity he holds to be mental sanity” (Crivellato and Ribatti 2007, 332). From the humoural perspective, the excess of black bile was thought to be responsible for melancholia, whilst the onset of phrenitis was due to the surplus of yellow bile (Cilliers and Retief 2009, 133). However, since the 1st century CE, Celsus advocated for the following categorisation of the three core forms of madness: “[1] acute afflictions associated with feverish diseases (phrenesis, phrenitis); [2] chronic mental illness without fever, associated with black bile (melancholia); [3] a particular chronic mental illness generally characterised by mental confusion and hallucinations, but sometimes by complete alienation (mania)” (Cilliers and Retief 2009, 133).

Acute illnesses, such as phrenitis, were believed to have an unexpected and sudden onset resulting in either the conversion to another disease, recovery, or death. Additionally, for phrenitis, its appearance accompanies a fever, results in one’s loss of reason, and yet its resolution is swift. On the other hand, chronic illnesses such as melancholia and mania, involved enduring anguish for the patient, recovery was indeterminate, and symptoms could re-emerge at any point at a later date. If a patient experienced loss of reasoning, which was chronic and did not accompany a fever – in

other words, could not be diagnosed as phrenitis – the patient was believed to be experiencing melancholia or mania (McDonald 2009, 113-15).

With regards to phrenitis, Cilliers and Retief state the following:

[I]t was identified as a sickness of one's body and their mind, it involved fevers and confusion, hyperactivity, periods of extended silence, disproportionate emotional responses, and hallucinations. The treatment options for one suffering phrenitis therefore included blood-letting, restraint (if hyperactivity was a cause for concern), suitable nourishment, and "hot or cold compresses (applied in accordance with the law of opposing forces) (Cilliers and Retief 2009; 134).

Melancholia was believed to be caused by an imbalance of one's humours, specifically, a build-up of cold black bile harmfully impacting one's brain. Melancholia was identified through symptoms such as insomnia, suspicion and mistrust, depression, suicidal thoughts, and extreme tearfulness, amongst others. It was said that the spring season saw the onset of melancholia due to "the seasonal welling up of the blood". Therefore, treatments for melancholia included "the removal of undesirable humours (black bile in particular) by means of purgation, vomiting or blood-letting (Cilliers and Retief 2009, 135).

Mania was classified as an illness involving mental instabilities without the presence of a fever, and was said to have numerous causes: intoxication, paranoia, catastrophising, hyper sexual activity, and, dangerous contact with heat or cold. Therefore, treatment for mania involved therapeutic vomiting, suitable nutrition, blood-letting, and a variety of calming methods: "calm conversations, music, story-telling, and even the theatre" (Cilliers and Retief 2009; 136).

It is noteworthy to observe the assortment of clinical symptoms one may experience in classical madness, and how they appear not too dissimilar to modern-day psychosis. In fact, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), there are several key features utilised to support the definition and diagnosis of a psychotic disorder: "delusions, hallucinations, disorganised thinking (speech), grossly disorganised or abnormal motor behaviour (including catatonia), and negative symptoms" (Diagnostic and Statistical Manual of Mental Disorders 2013; 87). Whilst it may be tempting to neatly categorise ancient madness into modern-day psychosis, it is important to note that mania, melancholia, nor phrenitis, completely

correlate. Two possible explanations for this may be: 1) no one person is made of the exact same composition, therefore every psychotic symptom is unique to that individual (Dols 1984; Bloch and Singh 1998; Bosman 2009; McDonald 2009; Ahonen 2014), and 2) one's context, society, and culture must be taken into account (Van der Eijk 2005; Bosman 2009; Ahonen 2014; Thumiger 2017). A similar concept of *cultural formation* is found in the DSM, which specifies that:

Understanding the cultural context of illness experience is essential for effective diagnostic assessment and clinical management. Culture refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems (Diagnostic and Statistical Manual of Mental Disorders 2013, 749).

From a modern biomedical framework, it appears that conceptualising mental illness through a cultural lens is “essential”, as indicated above. However, one may wonder whether this clinical stipulation is in fact implemented in clinical practice. Greco-Roman medical theory believed that understanding one's cultural context was crucial in the conceptualisation and effective treatment of mental illness (Dols 1984; Van der Eijk 2005; Ahonen 2014; Thumiger 2017). In fact, Dols states it this way:

To add to the complexity of the subject, culturally defined categories of abnormality shape the afflicted person's version of [their] inner experience and others' reports of [their] behaviour. There is, then, a complex dialectical relationship between the reports of the experiences and symptoms of the mentally ill, the cultural categories of mental disturbances, and the theories of the practitioner and observer (Dols 1984, 136).

The importance of cultural context shall be explored in further detail in Chapter Three and Chapter Four.

In surveying the ancient Greco-Roman medical literature, several important but also cautionary themes have emerged: many of the ancient Greco-Roman medical authors believed one's “cognitive centre” resided “somewhere in the body” (Van der Eijk 2005, 129); “the relationship between body and soul has no definitive answer” (Van der Eijk 2005, 124), although there are strands of medical thought that considered it to be bidirectional and sympathetic; cognitive faculties were not

exclusively considered *mental* or *physiological* (Van der Eijk 2005, 125); “what was considered a ‘disease of the soul’ in ancient medicine corresponds only in part to modern psychiatric categories” (Thumiger 2016, 85), although there are some interesting intersections and parallels; and, understanding the cultural context of a person suffering mental illness is paramount to conceptualisation and treatment (Dols 1984; Van der Eijk 2005; Ahonen 2014; Thumiger 2017). The following chapter will explore in finer detail the health and sickness of the soul, and the plurality of treatment approaches and philosophies.

CHAPTER 2 – The soul in Greco-Roman medical therapy/ies for psychotic episodes

Modern western medicine is derivative from various ancient Greco-Roman medical theories. For example, the way one considers, perceives and understands health, disease and insanity are largely derived from the central works of Hippocrates, Galen and other Greek and Roman physicians. Additionally, the various opinions and theories on one's soul, the body, and life itself, are a consequence of key philosophers like Plato, Aristotle and the Stoics (Van der Eijk, Schnalke and Kornmeier 2016, 11-12; Crivellato and Ribatti 2007).

In antiquity, there was no clear-cut distinction between medicine, religion and philosophy. Instead, there was an interwoven and interconnected relationship regarding the aetiology, origin, and diagnosis, which therefore informed the most appropriate course of treatment for a suffering individual (Van der Eijk 2005; Van der Eijk, Schnalke and Kornmeier 2016; Lewis 2016). Galen, in particular, was credited with bringing medicine and philosophy together, in what might be considered a multidisciplinary and holistic framework, for the purpose of appropriately supporting a diseased patient (Van der Eijk 2005; Van der Eijk 2016).

Caelius greatly opposed natural philosophy – like the work of Empedocles' dry, wet, hot and cold primary qualities – and instead adopted an empirical method and style, which encompassed dietetics (Van der Eijk 2005, 122-123). However, other physicians like Aristotle, Diocles, the Hippocratic author of *On the Sacred Disease*, Aretaeus, and even Galen, adopted more of a philosophical slant towards treatment believing that “the ‘civilised’ or ‘distinguished’ physician [...] is both a competent doctor and a philosopher skilled in physics, logic, and rhetoric” (Van der Eijk 2005, 123). In fact, for the physician Aretaeus, he believed in the relationship between a mentally ill patient and their treating physician, encouraging the patient to “be courageous and willing to cooperate with their physicians” (McDonald 2009, 109).

Mental wellbeing was believed to be of the utmost importance, in ancient medicine, in order for the *whole* of the body to function well. For example, “diseases of the mind” had the potential to disrupt “the soul's internal balance” thus threatening the soul's “connection with the rest of the body”. Preserving a healthy soul was vital for a well-functioning body (Van der Eijk 2016, 18). Therefore, the beginning of the 5th

century BCE saw the introduction of *intra-corporeal spaces*: the medical and philosophical investigation, and shared duty, concerning “the spatial mapping of the body and the soul, their respective functions and the diseases affecting them” (Van der Eijk, Schnalke and Kornmeier 2016, 10). This was the *medicine of the mind*. However, a dilemma that often plagued the ancient mental sphere was *how* and *who* would decide if someone was mentally unwell; “the patient or the doctor, the individual or the society, the philosopher or the priest, someone’s subjective experience or ‘scientific’ data[?]” (Van der Eijk, Schnalke and Kornmeier 2016, 10). Furthermore, Greco-Roman physicians quarrelled over issues concerning the localisation, classification, and therapy of a person experiencing mental illness. Was it appropriate to treat mental illness *physically*, through “surgery, medication or dietetic prescriptions”? Or psychotherapeutically? This contrast still exists today (Thumiger 2016, 86).

This chapter will examine several domains in the health and sickness of the soul. Firstly, natural medicine and philosophy will be explored including the use of dietetics. Secondly, the Pneumatists’ and the Methodists’ opposing philosophies will be surveyed. Thirdly, Hellenism and early Christianity will be examined, predominately involving the work of John Chrysostom. As one may expect, treatments varied depending on one’s view of aetiology, location, and the philosophy with which one operated. By the end of this chapter, it will be argued that a more holistic framework is required regarding the health and sickness of the soul, and therefore the treatment of a person experiencing psychotic episodes. The findings of a variety of key authors will be presented: in particular, Jessica Wright, Wendy Mayer, Robert Edwards, Philip Van der Eijk, Glenda McDonald, and Christopher Gill.

The health and sickness of the soul in natural medicine and philosophy

It is interesting to note that the close and delicate association “between genius and madness [...] find their origin in the darker, less controllable sides of human nature”, one wherein ancient Greco-Roman medical literature has had much to say (Van der Eijk 2005, 18). Various Hippocratic authors, including Alcmaeon, operated within the context of a cosmological and physicist framework (Van der Eijk 2005, 18). For Empedocles, being a natural philosopher, the mixtures of the fundamental elements – fire, air, water and earth – is what he considered to be the natural

phenomena impacting one's state of health and homeostasis (Van der Eijk 2005, 19; Stavros 2014). Therefore, everything within the cosmos experiences agony over the paradox and constant tug-of-war between Love and Strife, ultimately impacting the condition and health of the human soul (Stavros 2014). This wrestle between Love and Strife was considered responsible for managing and regulating one's emotions. In Fact, Empedocles believed:

The continuous change of those emotions in the human soul, results in the negative unpleasing feelings of anxiety, agony, depression and despair, which might be replaced by hope and serenity if only Love would dominate in the soul and restore the interior peace, integrity and existential harmony (Stavros 2014, 68).

However, according to Van der Eijk, rationalist physicians and philosophers desired to “demythologise” philosophers like Empedocles and Pythagoras, simply due to the fact that natural and rational philosophies did not fit comfortably with one another.

However, recently, Van der Eijk believes “there has been a renewed appreciation of the ‘mythical’ or ‘religious’ aspects of early Greek thought [where] there is now a much greater willingness [...] to accept the religious and ‘rational’ elements as coexistent and [...] compatible” (Van der Eijk 2005, 20-21).

Within the 5th and 4th centuries BCE, philosophers and physicians began to understand nutrition as a vital function for both the body and soul. In fact, “nutrition is the first [physical function] to take place when a living body comes into being; it thereby inaugurates the joining of the material body with the spiritual soul” (Korobili 2016, 68). Galen established a variety of principles that he believed conserved good health and prevented disease, a medical lifestyle treatment he elaborated on from his medical predecessors; “dietetics”. Dietetics was not solely the appropriate moderation of food and drink, it included additional lifestyle factors such as work-life balance, leisure and relaxation, health and fitness, sleep hygiene, massage, and even sexual activity (Korobili 2016; Van der Eijk 2016). Subsequently, if one's nutrition and health regimen was not established based on their needs, age and composition – or if one was malnourished – a consequence was bodily illness. In fact, nutrition was considered to be of such critical importance that Aristotle believed the “faculties of the soul cannot

exist apart from the power of nutrition”. Similarly, Galen held that “the higher functions of the soul are influenced by nutrition” (Korobili 2016, 70-73).

Aside from nutrition, movement was considered an equally significant therapy, in order to conserve and maintain one’s sense of well-being. Julião sums it up this way:

By exercising the body one improves both the natural and the psychic faculties of the organism: Walking after dinner facilitates digestion, and physical exercise not only strengthens the body’s organs, bones, tissues, and muscles, but, by sympathy, also sharpens the cognitive and intellectual capacities (Julião 2016, 78).

Galen took things a step further by suggesting that if exercise or movement is combined with pleasure, “it is of the greatest benefit both to the health of the body and the intelligence of the soul” (Julião 2016, 83).

The health and sickness of the soul for Pneumatists and Methodists

Caelius and Aretaeus were often in opposition; the former being a Methodist and the latter being a Pneumatist. As a Pneumatist, Aretaeus adopted the Hippocratic humoral approach concentrating on the equilibrium of the bodily humours and highlighting the importance of *pneuma* in regulating sickness and well-being (McDonald 2009, 107-108). As a Methodist, Caelius was indifferent towards, and even challenged, the humoral theory. Caelius believed treatment methods entailed treatment of the whole body without focussing on a particular bodily region, and it was not to be presumed that the origin of the illness was located in the ruling part of the soul (Bosman 2009, 6). Additionally, Caelius believed there were three possibilities, or “common states”, that caused illness and disease: “stricture, looseness, or a mix of the two” (McDonald 2009, 109). Whilst both camps held differing theoretical underpinnings, both philosophies adopted a symptomatology that distinguished amongst either the chronic or the acute nature of illness and disease (Bosman 2009, 5-6).

For Caelius, the symptoms of phrenitis may include: becoming cheerful and excited, depressed and sad, incoherent, and can even lead to behavioural changes such as violence, aggression, and hallucinations. Aretaeus appears to agree with Caelius’ views, he too asserting that phrenitis has the ability to onset intense confusion,

delirium and violence. Additional ailments, that both Aretaeus and Caelius believed might follow patients experiencing phrenitis, included: restlessness, heartburn, insomnia, breathing difficulties, hypochondria, nosebleeds, numbness and detachment of one's extremities, and even incoherent speech (McDonald 2009, 113-115).

For mania, both Caelius and Aretaeus believed its symptoms and onset could occur progressively or swiftly, could be displayed through behavioural changes such as laughing and playing, patients may obtain bizarre beliefs, and possibly even show hostility. Additional symptoms included a heavy head, swollen and enlarged veins, bloodshot eyes, one's ears ringing, and insomnia (McDonald 2009, 116).

Melancholia was understood as "more sorrowful in nature, with only the occasional moment of joviality" (McDonald 2009, 117). Caelius and Aretaeus both believed that melancholia led to paranoia of those around the afflicted patient, avoidance of public spheres, a preoccupation with death, and possibly risk-taking behaviour. Additionally, melancholia could present as withdrawal and isolation, dejection, headaches, "and physical aspects such as pain in the oesophagus [or vomiting] yellowish, rusty, or black matter" (McDonald 2009, 117).

The main point of distinction amongst Aretaeus' and Caelius' theoretical underpinnings, was their descriptions of the various causes and origins of phrenitis, mania and melancholia (McDonald 2009, 117). As mentioned above, a Methodist approach is to assess one's "common states" – stricture, looseness or a combination of both – by inspecting and observing one's bodily excretions: "mania is caused by the state of stricture, while phrenitis and melancholia are caused either by stricture or the mixed state" (McDonald 2009, 117). Additionally, Caelius identifies possible precursors that may impact one's common states, differing depending on the illness. For melancholia, these precursors may include fear, grief, indigestion, and vomiting regularly post food consumption. For mania, the precursors may consist of drunkenness, tension in one's mind, a disproportionate amount of grief or anger, and even severe cold or heat exposure. Therefore, treatment involved eliminating "these common states, relaxing or constricting the body as appropriate" (McDonald 2009, 117-126).

From a Pneumatist perspective, one's state of wellness relies on "an internal balance of the pneuma and the four elemental qualities – heart, cold, dryness and moisture", therefore, illness results from external and internal qualities like the "imbalance in the elements, or humours, climate, wine, deficiencies in the quality or quantity of one's food, wounds, medicines and even other illnesses" (McDonald 2009, 119). For Aretaeus, mania, phrenitis and melancholia are a result of extreme heat or dryness. Phrenitis presents when a surplus amount of heat overwhelms the chest and is then directed towards one's head. Whilst for melancholia and mania, if black bile travels to one's stomach, heat is generated, an odour is fashioned, and this odour may onset "irrational behaviour associated with mania and melancholia". Therefore, treatment needed to incorporate "cooling, moistening properties" (McDonald 2009, 119-125).

The health and sickness of the soul in early Christianity

A notion that must be understood here, is that of whether mental illness had its aetiology in demonic possession (an external cause) and to what degree a sufferer was considered to be personally responsible for their illness (internal cause). In the 4th century CE, "physical and psychological bases for insanity" were regularly embraced. Therefore, "Church Fathers generally recognized insanity as separate from demonic possession" and concurred with the psychological and physiological causes for insanity, including certain and diverse sustenance activating depression (Salem 2010). Furthermore, it was believed that one who was possessed was not considered evil, as having acquired a demon was not assumed to be the fault of the individual. Alternatively, if one was possessed by their "passions", or had obtained a disease of the soul, they were deemed culpable (Salem 2010; Mayer 2016). Therefore, themes of *willingness* and *responsibility* began to emerge as the precursor to therapeutic treatment, particularly for the homiletic philosophical-medical practitioner, John Chrysostom (Mayer 2015; Wright 2015).

John Chrysostom received his education in 4th century Antioch, a city that continued to embrace classical ideas, then went on to be "trained within the local Christian ascetical schools of the city", had exceptional rhetorical skills, was medically knowledgeable, and, became a preacher within what was at that time a factionalised

religion (Mayer 2016, 1-2). Whilst Chrysostom does not observe a specific “medical school”, he demonstrates competency amongst “a variety of medical authors”. In particular, Chrysostom aligns to the “humorist theory [...] and to an imbalance of the four humours as the cause of illness. Also found in his writings is the accompanying view that external factors, such as climate, seasons, and air quality, play a role” (Mayer 2015, 4). Chrysostom saw disease as a “metaphor for all forms of religious and social deviance and disruption” – sickness of the soul was equivalent to one’s sin (Mayer 2016, 22). As Lloyd posits, sickness of the soul could be conceived as both anthropological and societal; transferable to the church as a social group, and applied to deviant groups – heresy, if you will (Lloyd 1966). Accordingly, this “disease of the soul” was conceived as “a lapse into moral error”; how one stumbled into moral error was due to their disordered mindset. Therefore, treatment consisted of “ethical-philosophical therapy and with the identification and removal of false beliefs and their replacement with beliefs that are better-grounded”. For Chrysostom, this was “addressing an error of the *psychē*” (Mayer 2015, 343-344). Mayer states:

[T]he long-standing medical and philosophical concept that disease is caused by deviation from a norm [...] is fundamental and he expects that this is a widely understood concept. This ties into his adherence to the Stoic concept of indifferents and the idea that nothing is evil in itself. Rather it is the immoderate use of food (imbalanced diet), light, sound, wealth, wine, or even emotion [...] that leads to both physical and moral illness (Mayer 2015, 4).

Similarly, Thumiger postulates:

[M]oral deviance, expressed through reproachable behaviour, lack of self-control or failure to manage one’s passions [...] For others still, personal aspects such as spiritual imbalance, emotional suffering and existential anguish were central features: mental health thus became a more comprehensive matter of individual self-realisation, happiness and worth. Remarkably, discussions of mental pathology never adopted a neat separation between mind and body, but presented the two as intertwined and interdependent (Thumiger 2016, 85-86).

Therefore, with regards to treatment, Gill proposes that a physician able to operate within the psycho-medical sphere may be able to offer “extensive advice on how to rebuild one’s belief-set and thus to construct a framework of thinking (about actions, feelings, relationships, for instance) that provides a secure pathway to happiness” (Gill

2013, 348). However, Chrysostom cautions that for a narrative remedy to be an effective method of treatment, one must operate with repetition, commitment and patience; actively and willingly participating in “narratives [to] allow the structural judgements contained therein to change [one’s] beliefs” (Edwards 2020, 229; Gill 2013; Mayer 2015; Wright 2015). As Mayer posits, “it is not ever possible to force or compel this cure on anyone who does not wish to be healed” (Mayer 2015, 342). Through his concept of “shifting one’s mindset”, Chrysostom seems to have married narrative and medical thought together (Edwards 2020, 230). In fact, there is a growing body of research supporting the notion that Chrysostom may “be understood as a philosophical-medical practitioner, in which medical language is not mere metaphor, but is concerned with real cognitive remedies for ‘mental illness’ – soul sickness” (Edwards 2020, 226; Mayer 2015; Wright 2015; Mayer 2016). Moreover, it may be an interesting prospect to further explore and connect narrative with cognitive therapy; both remedies being of equal importance for, and implemented extensively by, John Chrysostom (Edwards 2020; Mayer 2015; Wright 2015), albeit within an explicitly Christian frame.

This chapter has reviewed a number of ancient therapeutic treatments and approaches in healing one’s soul and psychotic episodes. This has entailed: natural and philosophical remedies, including Galen’s dietetics; the Pneumatist and Methodist approaches; and early Christian methods through the work of John Chrysostom. Within early Christianity, it was established that demon possession was not only different to mental illness, but that demon possession was also not the cause of mental illness (Mayer 2015; Wright 2015). One of the key themes to emerge from this review is the notion of *willingness* and *responsibility* with regards to one shifting one’s mindset. The following chapter will now turn to modern research and literature in reviewing spirituality in mental health care, what neuroscience is now saying about spiritual practices impacting one’s brain, and the forgotten soul; the gut.

CHAPTER 3 – Current neuroscience and soul care

There is, in English, quite a narrow view and understanding of the term “spirit”, which has been understood to relate to *will* or *emotion* (Murphy 2006, 32), and even *energy* or *force* (Swinton 2001, 15). However, the very word “spirit” comes from *spiritus*, in Latin, being understood as *air*, *breath* or *wind* (Swinton 2001, 14). Additionally, Swinton cautions that whilst *spirit* and *spirituality* appear similar, they should not be mistaken to mean the same thing. If *spirit* can be understood as the very *air* that gives life, meaning and purpose to a human being, then *spirituality* can be understood as “the outward expression of the inner workings of the human spirit” (Swinton 2001, 20).

This chapter will identify and remind us that one of the main objectives in reviewing ancient Greco-Roman medical theory and philosophical literature, is to understand how it articulates and at times anticipates some of the prominent theories in modern-day neuroscience (Crivellato and Ribatti 2007). Therefore, this chapter will begin with a review of the role of spirituality in mental health. This will demonstrate how a person suffering from a mental illness has often had their spiritual needs unmet due to a dominant biomedical model, and anxiety around the connotation of the word *soul*. This will lead into a survey of current neuroscience and what contemporary research and literature is now identifying about the impact of spiritual practices on the human brain. This will recognize a particular brain region named the anterior cingulate circuit, and its significance and stimulation through various spiritual practices. Furthermore, the implication and consequence of modern neuroscience’s concept of the *brain* will be paralleled with the ancients’ view of the *soul*, leading to a review of the forgotten soul: the gut. It will be argued that in observing contemporary neuroscience, there now appears to be a connection and correlation to how the ancient Greco-Romans viewed a sympathetic body and soul. The key authors being analysed in this chapter include John Swinton, Christopher Cook, Nancy Murphy, Harold Koenig, Jay Lombard, Timothy Jennings, Andrew Newberg, Bessel Van der Kolk, Elio Frattaroli, and Emeran Mayer.

Spirituality and/in mental health

Broadly speaking, spirituality is conceived as being somewhat personal and unique to an individual, whilst religion is considered to be organised (Koenig 2009).

More explicitly, religion is deemed to be a set of culturally established and systematic beliefs, whilst spirituality is believed to relate to the meaning of life, connectedness to humanity, relationships, and harmony with the universe (Penman, Oliver and Harrington 2009, 30).

Whilst it appears there has been increasing research to indicate that society has made considerable advances in understanding spirituality and mental health, it would seem that both spirituality and mental health can continue to be misunderstood and stigmatised in a dominant biomedical model (Swinton 2001). The biomedical model asserts that a mental illness is “a neurological glitch [that promises] an easy chemical normalization without ever having to confront the existential crisis that is at the centre of [one’s] pain” (Frattaroli 2002, 11). Consequently, it is common for concepts of “growth, value, hope, meaning and purpose [to be] frequently excluded” by the influence and dominance of the biomedical model (Swinton 2001, 8). This may signify why people experiencing mental health issues believe their “spiritual desires are often quenched by the insensitivity and spiritual blindness of contemporary mental health practices” (Swinton 2001, 9). Interestingly, people experiencing mental illness can actually have their spiritual resources be a protective factor, if these resources are indeed valued and understood by their wider treatment team (Koenig 2009). Therefore, whilst religiosity may appear increasingly outdated to some, it is a miscalculation to consider that spirituality and spiritual practices have also become irrelevant; spirituality is still “highly significant to many people with mental health problems, even though they may not express an interest in or adherence to an established religious tradition” (Swinton 2001, 11-12). Thus, there is in fact growing evidence to support the role of spirituality in mental health practice: “spirituality is a common human phenomenon that is encountered in various ways in *all* human beings” (Swinton 2001, 10); spirituality and religion are meaningful and consequential themes for psychiatric patients (Petee 2017); spiritual practices and experiences offer considerable meaning to those experiencing psychiatric difficulties (Kroll and Sheehan 1989, 112); spirituality can be of momentous importance for people experiencing psychiatric illnesses (Neeleman and Lewis 1994); data gathered from a patient’s perspective of their mental illness has been vital in understanding the role of spirituality and spiritual care (Rudolfsson and Tidefors 2015); the importance of

spiritual and pastoral care services in the mental health sector continues to grow (Forrester-Jones et al. 2017); the protective factors that spiritual practices offer in mental health recovery continues to be explored and recognised (Ødbehr et al. 2015); and, “spirituality may protect against stress-related mental disorders” (McClintock 2019, 1). Research appears to identify that a patient suffering from a mental illness, desires to have their religious and/or spiritual needs taken into account within their treatment (McCord et al. 2004). This necessitates spiritual care and spiritual practices being incorporated into psychological and psychiatric practices (Tepper et al. 2001), especially considering this sort of personalised and holistic care is typically not implemented (Coffey et al. 2019, 15).

According to Bloch and Singh, even psychiatrists recognise that the classification of psychiatric disorders can be somewhat limiting regarding “the complexity of either the clinical picture or the uniqueness of the suffering person” (1997, 41). It is significant to consider that whilst the notion of a more holistic framework continues to gain momentum amid increasing clinical evidence, there still remain several reasons why spirituality and religion may be ignored in treatment. Firstly, spirituality and religion tend to be overlooked due to the difficulties in their conceptualisation and operationalisation in treatment (Koenig 2008). Secondly, due to the profitability of pharmacological conglomerates, non-drug treatments are seldom published and are often considered alternative (Van der Kolk 2014). Thirdly, as Swinton points out, there are a variety of explanations as to why spirituality and religion may be disregarded in clinical practice: professional arrogance and research credibility, lack of time due to staff/patient ratio, psychiatrists and the wider treatment team being unsure of their own spiritual values and beliefs, anxiety concerning incompetence, and, lack of understanding or education of spiritual and religious matters and their relevance in clinical care (Swinton 2001, 42-45).

A particularly sad example is shared by Jay Lombard, a medically trained neurologist who reports a clinical story of a patient who was dying of cancer. Despite Lombard being unable to offer any further clinical treatment, for twenty-five days he continued to speak at length with his patient, offering her a sense of relational connection and presence, and engaging in what he called “housekeeping matters” – which sounds remarkably like spiritual care. On the twenty-fifth day Lombard advised

his chief resident that there were no other options for his patient, and the next day, his patient died. Lombard reflected on how he “greatly undervalued and minimized the nonclinical side of medical care [which appeared to carry] much more importance than [he’d] thought” (Lombard 2017, 11-12). In fact, Lombard went so far as to state that “we doctors believe that if we can’t measure something then it’s not real or doesn’t exist” (Lombard 2017, 12). However, as the next section will demonstrate, what neuroscientific research is now indicating regarding the brain and spiritual practices, increasingly supports the relevance of spiritual care in clinical practice.

What neuroscience is now saying about the brain and spiritual practices

Neuroscientific research is not only offering “a window into the material basis of our immaterial existence”, it is also demonstrating that, in a spiritual state, one transcends from their material and physical brain structure (Lombard 2017, 13-35).

Research is continually signifying that spiritual beliefs, involvement, experiences and practices, are not only having an impact on one’s mental health, they are impacting one’s neurobiology and neurochemistry – endlessly indicating the relevant role for spiritual care (soul therapy) in clinical practice (Rim et al. 2020). However, before we proceed, it will be acknowledged that the term “religious and spiritual (R/S) practices” will be indicative of mindfulness, meditative, contemplative, breathing, spiritual and religious practices, unless otherwise explicitly stated. Moreover, the term “God” is not referred to here in a religious sense; “God” will be representative of an idea, experience, image, thought, perception, feeling, truth, or fact (Newberg and Waldman 2009). Additionally, whilst this thesis will adopt the language of “God”, the reader is free to adopt their own language or terminology in replacement: Spirit, the Universe, Nature, the Divine, the Sacred, Higher Power, Energy, and so on. One’s conception of God is somewhat irrelevant; the neurological benefits of one’s *personal* conception of “God” is what is of clinical significance and importance (Newberg and Waldman 2009; Lombard 2017).

Contemplating God is not only a persistent neurological concept that will not cease, brain studies are now indicating that the human brain is hardwired for this ability (Lombard 2017). In addition to this, contemplating God has neurological impacts on one’s brain including: the formation of dendrites and synaptic networks,

variations in dopamine and serotonin levels affecting neurotransmitters, particular neural circuits being stimulated and activated, and other neural circuits being rendered deactivated (Newberg and Waldman 2009; Rim et al. 2020). This may be considered a modern-day example regarding the sympathetic relationship between the body and soul – or brain (Lombard 2017, 41). Nevertheless, amongst several findings that R/S practices impact neurochemical variations in one’s brain, Newberg and Waldman concluded:

[1] Spiritual practices, even when stripped of religious beliefs, enhance the neural functioning of the brain in ways that improve physical and emotional health. [2] Intense, long-term contemplation of God and other spiritual values appears to permanently change the structure of those parts of the brain that control our moods, give rise to our conscious notions of self, and shape our sensory perceptions of the world. [3] Contemplative practices strengthen a specific neurological circuit that generates peacefulness, social awareness, and compassion for others (Newberg and Waldman 2009, 5).

Furthermore, there are specific neurological connections within the human brain that are stimulated by R/S experiences and practices; neurological connections that would otherwise be sedative, further supporting the clinical relevance for implementation of R/S experiences and practices (Rim et al. 2020). There is a noteworthy statistic identifying that at least 90% of our current global population has some involvement or participation in R/S practices (Koenig 2009; Lombard 2017). This statistic is significant for several reasons: regular involvement in R/S practices has demonstrated an association with lesser levels of mental health conditions (Chen 2018); mindfulness and contemplative practices demonstrate a positive impact on a variety of psychosomatic and psychiatric symptoms, cortisol levels, blood pressure, immune system, and emotional regulation (Van der Kolk 2014); and, R/S experiences and practices have a significant bearing on “mood, psychotic, anxiety, and substance disorders” (Rim et al. 2020, 3). Rim et al.’s meta-analysis of R/S experiences and practices, and their neurobiochemical relationship, also established numerous functional and structural transformations in a variety of brain areas (Rim et al. 2020). However, there is one brain region of particular importance that this thesis will focus on; the anterior cingulate cortex (ACC). One of the noteworthy, and recently evolved, tasks of the ACC is to manage the balance and equilibrium of one’s thoughts and

feelings – essentially bridging the gap between the limbic system and the frontal lobes; bringing our rational and emotive faculties into harmony (Lombard 2017; Tang et al. 2019; Basile et al. 2020; Lewis, C et al. 2020). Interestingly, the ACC has been affectionately termed the brain’s “neurological heart” (Newberg and Waldman 2009; Jennings 2013).

The anterior cingulate cortex

The anterior cingulate cortex’s location within the brain appears to demonstrate great importance: its position is within a critical communication intersection amid the limbic system and the frontal lobe where numerous spiritual notions and perceptions are fashioned. The stimulation and firing of the ACC is striking due to its unique role in increasing and improving empathy, consciousness, intuition, emotional regulation, social awareness, the ability to choose between right and wrong, and, love (Newberg and Waldman 2009; Jennings 2013; Lombard 2017; Lockwood et al. 2020). At the same time, its stimulation is responsible for pacifying feelings of anxiety, depression, irritability and other damaging emotions such as anger, guilt, distrust and fear (Jennings 2013; Lewis, C et al. 2020; Rim et al. 2020). Whilst these emotions are not altogether troublesome, and at times quite necessary in generating responses to threatening conditions, Newberg and Waldman assert that anger is almost certainly the emotion to inhibit regular brain functioning, specifically within the frontal lobes. Interestingly enough, spiritual and religious practices play a significant role in overturning the brain’s tendency to respond with, and resort to, fear, distrust or anger. This ability of the brain to overturn these, at times, negative emotions is enabled when the ACC and frontal lobes experience a surge in blood flow. This surge in blood flow is stimulated by spiritual and religious practices (Newberg and Waldman 2009). Moreover, when the ACC is stimulated, one’s neurological heart becomes stronger and is able to pacify the painful experience and emotion of guilt (Jennings 2013). Alternatively, if this particular neural circuit within the ACC were to malfunction or become damaged, it can lead to fertile ground for mental health issues like post-traumatic stress disorder, mood disorders, anxiety disorders, obsessive-compulsive behaviour, and psychotic disorders (Newberg and Waldman 2009; Lombard 2017; Lewis, C et al. 2020; Lockwood et al. 2020). Thankfully, increasing

research appears to demonstrate that spiritual and religious practices hold great efficacy in the treatment of significant mental health issues (Rim et al. 2020). It is through these R/S experiences and practices that the human brain is not only able to strengthen its neuroplasticity and cortical thickness, measurable development and growth can also be recorded within the ACC (Newberg and Waldman 2009; Jennings 2013; Lombard 2017; Rim et al. 2020).

However, what must also be understood here, is the possibility that various religious and spiritual practices can be considered harmful to, and for, one's brain – especially if there is an association with fear, guilt, disconnection, punishment or judgement (Newberg and Waldman 2009, 57). It is interesting to note that the word *religion* is derived from Latin meaning “to bind together”; consequently, “at its best the truly religious experience connects us to others [whilst] a false religious experience divides us” (Lombard 2017, 149). Therefore, poignantly, Pargament and Koenig's research showed that “religious struggle” had the probability to predispose depression, impact one's physical health, affect one's recovery from disease and sickness, and also led to a reduced life span (Pargament et al. 2001). More specifically, if one has persistent fear-based or unhealthy beliefs relating to their experience of spirituality or religion, it may become harder to separate one's guilt from their potentially self-destructing or damaging behaviours. This is due to the fact that one's neurological heart – the ACC – is the point of intersection between one's emotions and judgements, ultimately being the brain region responsible for making choices (Jennings 2013; Tang et al. 2019; Basile et al. 2020; Lockwood et al. 2020). This appears to expose two critical areas: 1) the religious or spiritual practice being undertaken must hold some form of *personal* meaning, significance and importance, in order for the practice to induce a positive and protective change in one's neurochemistry (Newberg and Waldman 2009; Lombard 2017; Rim et al. 2020), and 2) it would appear to be negligent if these psychospiritual issues were not acknowledged and addressed by health-care, especially if one adopts the notion that health issues are spiritual, just as much as they are medical (Newberg and Waldman 2009).

One of the difficulties for the neurosciences is in part due to the fact that neuroscience is unable to offer sufficient responses to life's larger questions around whether there is a God, the reality of spiritual realms and experiences, and the wider

nature and character of the cosmos (Murphy 2006, 68). However, whatever belief one holds seems to be a point of indifference for the human brain; the only *spiritual truth* the brain seeks to comprehend is whether one's *personal* notion of God – again, an idea, experience, image, thought, perception, feeling, truth, or fact – is a source of protection or destruction (Newberg and Waldman 2009; Lombard 2017). This paradigm shifting research postures an important question: what would it do to the way we approach counselling and therapeutic practice, if we equate the anterior cingulate cortex to the soul, given that the anterior cingulate cortex is the heart of one's neurological soul, the brain?

The gut; the forgotten soul, and understanding sympathy from a modern perspective

As this thesis has demonstrated, throughout antiquity the brain and the heart received the most attention regarding the primacy of the ruling seat of the soul. The gut received significantly less attention, and was also considered the lowest of the hierarchical souls (Van der Eijk 2005; Murphy 2006; Crivellato and Ribatti 2007). However, through increasing neuroscientific research and literature, it appears the gut has been demonstrated to be quite significant (Mayer, E 2018).

Mayer highlights several key findings: the gut is referred to as the “second brain”; it overwhelmingly validates the inextricable and complex biological relationship linking the human mind and the digestive system together; the gut and the brain do not function in isolation from one another but as part of a whole; the microbes within one's gut impacts one's emotions, decisions and cognitive functioning; and, the gut has the largest storage facility of serotonin in the body (Mayer, E 2018, 6-18). In fact, when one experiences powerful emotions (or passions as Galen would refer to them), the brain is not the only organ required. The heart and the gut are also essential, closely interacting and collaborating with the brain (Van der Kolk 2014, 76). If one were to experience something shocking or devastating, we often speak of it as *gut-wrenching* or *heart-breaking*. From a modern perspective, whilst the brain may still be considered the *hēgemonikon*, it does not and cannot operate in isolation. The brain requires “chemical messages [from] the bloodstream and electrical messages [from] our nerves [which causes] subtle or dramatic changes throughout the body and brain” (Van der Kolk 2014, 94). Therefore, whilst the brain is required to

rationally understand a painful experience, it is the heart and the gut where those painful experiences are often *felt*. This may further highlight that one's thoughts or beliefs pulsating within their brain may greatly affect and influence one's body (Lombard 2017, 43).

Whilst many of the ancient Greco-Roman physicians and philosophers identified the three primary areas for the bodily souls – the brain, heart and gut – perhaps it is not about which of the bodily souls is the *hēgemonikon* at all. Whilst the brain may still be considered the primary organ holding rationality, contemporary neuroscience appears to now offer several additional concepts that propose the uniqueness, impartiality and equality amongst the brain, heart and gut. These include how the health of the gut dramatically impacts the health of the heart and brain, how the anterior cingulate cortex has been referred to as the brain's *neurological heart*, and amongst other things, how the gut has been referred to as the *second brain* (Newberg and Waldman 2009; Ma et al. 2017; Breit et al. 2018; Mayer, E 2018).

What may be considered an interesting anecdote, is the way in which the brain, heart and gut are able to communicate with one another. Amongst others, Charles Darwin was fascinated with the body-brain relationship, and spoke of what is called the *pneumogastric nerve*; the nerve responsible for the “heart, guts, and brain [to] communicate intimately [and] the critical nerve involved in the expression and management of emotions” (Darwin 1998, 71-72). In contemporary literature, this nerve is now called the *vagus nerve* and its purpose is striking. Not only does the vagus nerve have multiple branches for its numerous functions, one of the purposes of the vagus nerve is to connect various organs including, but not limited to, the brain, heart and gut – essentially connecting the brain with and to the body (Van der Kolk 2014, 78). Whilst the vagus nerve is not the focus of this thesis, it seems significant to understand some of its functions, in order to appreciate its importance in allowing for a sympathetic body and soul. Several of the significant functions of the vagus nerve include: it is the nerve that recognises heartache and gut-wrenching emotions (Van der Kolk 2014, 81); it connects the brain to the gut, linking the vagus nerve's health to various psychiatric conditions (Breit et al. 2018); it is partly responsible for the birth of new neurons (Gebhardt et al. 2013) – coincidentally, *neuron* is the modern word for *psychic pneuma* (Crivellato and Ribatti 2007, 335); and, appropriate stimulation of the

vagus nerve has an array of health benefits including reducing anxiety, enhancing sleep quality, improving cardiovascular health, lowering blood pressure, and boosting brain health (Ma et al. 2017). However, perhaps one of the most interesting facts about the vagus nerve is its name: “vagus” is derived from Latin meaning *wandering* – quite fitting given it is the longest cranial nerve emanating from the brain and wandering throughout the body (Krahl 2012). This *wandering* vagus nerve may initiate a paradigm shifting idea: that perhaps the mind – or rational soul – is not solely localised to the human brain at all (Van der Eijk 2005; Cilliers and Retief 2009; McDonald 2009; Holmes 2013; Lewis 2016; Van der Eijk 2016; Lombard 2017, 45). Perhaps to adopt a holistic view of the human person is to revert back to one of the ancient Greco-Roman philosophies that one’s mind is not necessarily localised to one’s brain. It may be possible that one’s mind roams throughout the body, further supporting the equality and impartiality amongst the predominate bodily souls: the brain, the heart, and the gut. Nevertheless, if we are to accept a sympathetic body-soul relationship, and the primacy of the brain-heart-gut relationship, it requires an important and vital shift in our biomedical therapeutic underpinnings – one in which “alternative” and nonpharmacological treatments are accepted and employed, just as they were, and have been, outside modern Western medicine (Van der Kolk 2014).

The following chapter will now explore the possible implications these emerging notions have on clinical practice and contemporary care.

CHAPTER 4 – Implications for contemporary care

One of the dangers in viewing the soul through a physiological and neurobiological lens is the dominance of reductionism (Swinton 2001; Frattaroli 2002; Murphy 2006). Frattaroli offers a strong opinion on the matter:

The pervasive doctrine of scientific [reductionism] – the assumption that mind and soul are merely by-products of brain activity – makes it all too easy to persuade ourselves that there is [...] no need to examine the inner life of the soul in psychotherapy. I believe that the unchecked influence of this materialist philosophy is destructive to Western culture [...]. What this has led to [...] has been a politically endorsed, corporately sponsored psychiatric drug culture that now threatens to destroy the practice of psychotherapy altogether (Frattaroli 2002, 20-21).

Van der Kolk also cautions against the leading biomedical model, asserting that its focus and aim is to identify the chemically correct pharmacological treatment of a “disorder”. This inevitably distracts one from looking within and wrestling with how their difficulties may be hindering their daily functioning, their relationship with themselves, and their relationship with their wider community (Van der Kolk 2014, 79). Additionally, Van der Kolk theorizes that one can alter their physiology and internal balance through means other than pharmacology – and the fact that this is rarely considered can have a dangerous effect on one’s mental health, and the wider society (Van der Kolk 2014). As specified by Bloch and Singh, “mental illness does not respond to recipe-link remedies” (Bloch and Singh 1998, xii). However, According to Murphy, the implication of neuroscience postulates that the capacities once credited to the soul now seem to be understood as functions of the human brain (Murphy 2006, 5). Moreover, Young posits that the ancient soul may now be considered equivalent to one’s central nervous system – the incorporation of one’s spinal cord and brain (Young 2020). From an ancient Greco-Roman perspective, one’s rational soul lies within the human body. Therefore, Murphy’s argument need not be in conflict with the ancient origins of Western medicine – in fact her position appears to support it – calling this *non-reductionist physicalism* (Murphy 2006, 5).

In exploring the implications for contemporary care, this chapter will highlight two areas: the significance and consequence of the soul being understood and treated from a neurobiological and physiological viewpoint, and the relevance and

appropriateness of spiritual care in the clinical treatment of a person suffering from a psychotic episode. Key authors engaged with in this chapter include Nancy Murphy, John Swinton, Christopher Cook, Robert Edwards, and Isabel Clarke.

Understanding and treating the soul from a neurobiological and physiological standpoint

As has just been argued, the implication of neuroscience postulates that the capacities once credited to the soul now seem to be understood as functions of the human brain (Murphy 2006, 5). The intricacies of our neurobiology allow for the development of our higher abilities: free will, ethics and morality, and spiritual consciousness, to name a few. However, as human beings we are not simply the sum of our parts. These higher proficiencies develop through connection and relationship with ourselves, our wider community, and to a Higher Power beyond ourselves (Murphy 2006). This statement alone may highlight the biological and theological relationship that exists regarding the human person as a whole; that a pure reductionist or physicalist approach is not sufficient in understanding the human person. Therefore, Murphy posits two arguments:

First, that we are our bodies – there is no additional metaphysical element such as a mind or soul or spirit. But, second, this “physicalist” position need not deny that we are intelligent, moral, and spiritual. We are, at our best, complex physical organisms, imbued with the legacy of thousands of years of culture, and, most importantly, blown by the Breath of God’s Spirit; we are *Spirited bodies* (Murphy 2006, ix).

Current literature appears to suggest that ancient Greco-Roman medical theory, and contemporary neurosciences, are both identifying the roadmap forward: a non-reductionist physicalist approach to the human person. Murphy sums it up this way:

The non-reductionist physicalist says [...] if there is no soul then [the] higher human capacities must be explained in a different manner. *In part* they are explainable as brain functions, but their *full* explanation requires attention to human social relationships, to cultural factors, and, most importantly, to our relationship with God (Murphy 2006, 70).

This may raise the question of *who* am I, if I possess no soul? Is not my soul that which characterises my personality, identity, and individual uniqueness? How might spirituality be of significance if I don't have a soul? Firstly, Murphy again argues that human beings form their identity and uniqueness through the neurological outworking's of their brain: a sense of self, memory, consciousness, relationship with others, morality, and more. This further supports the notion that these functions of the human brain were once attributed to the rational soul (Murphy 2006, 5). Secondly, regarding spirituality, Thomas asserts quite a relevant and applicable notion:

[Spirituality] is most fruitfully defined as the sum of all the uniquely human capacities and functions: self-awareness, self-transcendence, memory, anticipation, rationality (in its broadest sense), creativity, plus the moral, intellectual, social, political, aesthetic, and religious capacities, all understood as embodied (Thomas 2000, 268).

This would appear to highlight two key arguments: 1) one needn't be concerned with the religious or supernatural connotations of *soul*, as it can be understood from a neurobiological and physiological perspective, and, 2) this therefore further supports the role of spiritual care services in clinical practice for a person suffering psychotic episodes.

Not only were ancient philosophers and physicians able to hold opposing views, it appears there is still room in our post-modern society to hold varying interpretations of the nature of humanity. Whilst a non-reductionist physicalist approach may argue that a human being is their body and has no separate soul, the position still holds room for the claim that a human being has the capacity for higher functions and cognitions including emotional regulation, consciousness, capacity for empathy, ability to connect with God or that which is beyond ourselves, and so on. Not dissimilarly, an ancient Greco-Roman physician or philosopher would refer to these higher capabilities as functions of the rational soul (Murphy 2006, 15). If modern-day psychiatry were to adopt a non-reductionist physicalist approach, and yet continue to use the language of *brain*, one needn't feel the spiritual or supernatural loss over the term *soul*. Lombard suggests that all one has to do is observe the human brain's anatomical resemblance to that of the cosmic universe, to see that the human

brain can still be conceived as spiritual or supernatural – just as the soul was once believed to be, and still is for many (Lombard 2017, 31).

The inclusion of spiritual practices in holistic treatment of psychotic episodes

What appears to emerge from the literature is the notion of *meaning*. Victor Frankl, the father of logotherapy, identified that “a failure to find meaning” is what led to one’s suffering (Allport 2004, 8). More recently, Baumeister and Vohs believe that humanity not only has an inborn need to find and create meaning, but without it, human beings may have the propensity for distress (Baumeister and Vohs 2005). Not only so, when one finds meaning in their existence – and in their experience – it is proposed that they are less likely to need therapy, experience suicidal thoughts, or suffer from an array of mental health conditions (Bryan 2020). Patients experiencing mental health issues, more specifically psychotic episodes, often seek to understand their experience and assign some form of meaning to it (Kroll and Sheehan 1989; Swinton 2001; Rudolfsson and Tidefors 2015; Cook 2016; Forrester-Jones et al. 2017; Cook 2020). This has also been understood to allow a clear role for spiritual and pastoral care services: offering space to an individual in order for them to narrate their experience and find their own meaning (Cook 2016; Cook 2020). After all, Lombard believes that all humanity is seeking meaning, which is fundamentally achieved through our relationships: “ultimate meaning is discovered through our connectivity”, be it with ourselves, our community, nature, the wider universe, and so on (Lombard 2017, 106). This notion of offering connection to a person appears to further support the role of clinical spiritual care.

From a therapeutic standpoint, one of the supportive approaches for a person to establish their own meaning, a sense of self-discovery, and self-reflection, is storytelling, or narrative therapy (Cook 2016; Swinton 2018; Cook 2020). Kinsella postulates that through self-reflection and relationship with others, narrative therapy and storytelling become fundamental to the way in which one forms their sense of self and their belief systems (Kinsella 2006). Therefore, narrative therapy, being a key element of spiritual care, becomes vital in encouraging recovery, regaining one’s agency, establishing meaning, altering belief patterns, and, creating one’s sense of self (Care Services Improvement Partnership et al. 2007). Despite the fact that a person

suffering psychotic episodes may be in a place of enormous pain and confusion, “it is still possible to find ways of promoting a positive concept of self, amidst the experience, and to offer hope and meaning” (Clarke et al. 2016). Therefore, narrative therapy is considered person-centred, holistic, it stimulates research, aids in establishing appropriate therapeutic and diagnostic options, and offers numerous possible interpretations for the mentally ill person in generating their own meaning (Cook 2016, 2). Narrative therapy encourages people suffering psychotic episodes to view their narrative as one of potential transformation; that within their pain there may be the possibility of self-discovery and growth (Clarke et al. 2016). In fact, Clarke et al. goes so far as to state that there is epidemiological evidence suggesting that societies who have adopted a broader and more holistic approach to health, which incorporates narrative and spiritual conceptualisations, have had better outcomes for those experiencing schizophrenia, and by association, psychotic episodes (Clarke et al. 2016). In fact, Blazer found that various spiritual, religious and faith-based communities offer a mentally ill person hope, narrative and meaning. This appeals to a person’s fundamental human nature, allowing for completely authenticity, self-expression, and self-exploration, amidst the angst of mental illness (Blazer 2017). As Cook asserts, “the signs and symptoms of mental illness are many and diverse and they concern the very essence of our experience of what it is to be *human*” (Cook 2020, 164).

It appears from various scholarly works that John Chrysostom may have been quite ahead of his time regarding some of the principles of neuroscience and narrative therapy. For example, Chrysostom believed several things to be true: “cultivation of thoughts takes on a narrative form” (Edwards 2020, 214); “narration thus becomes a project of a change in perspective” (Edwards 2020, 221); “narrative ills are healed by narrative remedies” (Edwards 2020, 216); and, “emotions are cognitive: thus, if the therapist can alter a cognitive judgement through the continual telling of stories, the emotion will be changed” (Edwards 2020, 207; Wright 2015; Mayer 2016). This may demonstrate the possibility of Chrysostom’s method uniting neuroscience with narrative therapy, highlighting two areas: 1) narrative therapy may have the potential to alter or challenge one’s thoughts through the principle of neuroplasticity (the brain’s ability to change or alter itself), and 2) narrative therapy may be considered an

appropriate therapeutic approach, within clinical spiritual care, for those experiencing psychotic episodes. Although Chrysostom's reference to narration was his use of biblical and scriptural homilies (Edwards 2020), it is possible – and perhaps appropriate – that the practice of narrative therapy be extrapolated to patients narrating their own story, finding meaning, and judging or assessing their own cognitive state. As indicated by Chrysostom, “judgements and narratives are closely bound together” (Edwards 2020, 213).

This may be considered an additional implication for contemporary care: recognising that the predominant modes of treatment from a biomedical model may not be solely sufficient in treating a person experiencing psychotic episodes. Treating one's brain through pharmacological methods may still be appropriate in order to alter their brain chemistry and provide relief from distressing or debilitating symptoms. However, this is not the only treatment method available, nor is it considered a holistic view of the *whole* person – there is an invitation to explore and implement additional methods of clinical treatment. Narrative therapy need not oppose, or compete with, existing clinical practice. However, from a holistic perspective – and one seemingly advocated by John Chrysostom – the treating physician must be able to hold space for both the diagnosis and the narrative to co-exist (Cook 2016, 5). Cook states it this way: “Storytelling is thus at the heart of both medicine and pastoral care. The doctor, like the priest, needs to be good at listening to stories” (Cook 2016, 1).

CONCLUSION

This thesis has journeyed through the rich history of ancient Greco-Roman medicine and philosophy, appears to have uncovered some lost treasures along the way, and may have discovered some new pearls of wisdom.

Throughout the time of René Descartes, not only did a body-mind (soul) dualistic account of a human being become increasingly accepted, language began to shift from “soul” to “mind” to avoid religious implications and connotations.

Therefore, sensations and consciousness were attributed to one’s mind, whilst every other ability or faculty was accredited to one’s body (Murphy 2006, 45). This notion does not appear to be altogether incorrect, though it appears limiting.

Treating mental illness as a neurological disease is not erroneous. However, throughout history there has been relentless deliberation between science and religion, the body and the soul, and, the natural and the supernatural. What was once understood as a sickness of the soul is now understood as a disease of the brain. Both may be correct. However, within a biomedical model there is a much narrower and limiting view of the brain; reductionism if you will.

Treating the *mind* in modern day psychiatry is only viewing part of the person as opposed to the *whole* person. As it has already been established, *mind* is translated from the Greek word *nous*, which was representative of the rational soul. Therefore, if modern day psychiatry is simply treating the rational mind – assuming it is located in the brain – then the wider *psyche* of the human person is being neglected. One needn’t be afraid of the spiritual, religious or supernatural connotations associated with the word *psyche* or *soul* – the implication of neuroscience postulates that the capacities once credited to the soul now seem to be understood as functions of the human brain (Murphy 2006, 5). One needs to understand that to treat the brain *is* to treat the rational soul – more specifically – the rational soul residing *somewhere* in the body, potentially incorporating one’s brain, heart, and gut. Perhaps this is what it means to operate within a *holistic* framework. What impact might it have on clinical practice and outcomes, if we took up Galen’s legacy and bridge the gap between medicine and religion, natural and supernatural, body and soul?

The research appears to support that a pre-Cartesian view of the human person is now supported by recent neuroscientific and medical research. Furthermore, the

unveiling of contemporary neuroscience has not only revealed the possible health benefits associated with various spiritual and religious practices, the literature has seemed to uncover a variety of implications for the clinical implementation of spiritual and pastoral care services in mental health care.

According to Van der Eijk, whilst ancient Greco-Roman medical theory sought to provide natural explanations for madness, there was still a degree of willingness to observe the “superstition, folklore, religion and magic [of madness] than was generally believed”. This now stands in opposition to the contemporary view of a *superior* Western medical paradigm, over *alternative* or *complimentary* therapies, claiming it to be outdated and politically incorrect (Van der Eijk 2005, 4). In fact, there is now greater openness to the broader meaning of what ancient Greco-Roman medicine truly entailed, and contemporary medicine is invited to contemplate and reflect on the relationship “between medical ‘science’ and its environment – be it social, political, economic, or cultural and religious” (Van der Eijk 2005, 6). As Cook states, “mental well-being is experienced in community, not in isolation” (Cook 2020, 165).

It must be acknowledged that increasing literature appears to demonstrate the pursuit of a more holistic and harmonious relationship between spirituality and mental health. Lombard supports a collaborative relationship, asserting that there can be a mutual respect between “the biological and the transcendent” in order for one to be able to impact the other in a positive manner” (Lombard 2017, 7). In fact, given that Newberg and Waldman believe the spiritual and religious landscape within culture is ever growing and transforming, it may be argued that religion and spirituality must be observed through a cultural lens, in order for its *personal importance* to be understood within mental health care and practice (Newberg and Waldman 2009).

One may wonder if the biomedical model offers enough attention to the cultural, religious and spiritual aspects of mental illness. Concerning the prevailing separation of spirituality and mental health within the biomedical model, it is important to recognise, as we have learnt, that “such a separation would be completely alien to [the] classical thinking of the [ancient] Roman civilization” (Cook 2020, 128). A more holistic approach to psychotic episodes is one in which spiritual care becomes integral to clinical practice, as a result of a more holistic understanding of the human person. What therefore appears to emerge from the ancient Graco-Roman medical

literature is the idea that medicine is actually an interdisciplinary and fluid field, designed to be much more holistic than what the current biomedical model offers or represents (Van der Eijk 2005). Thus, it may be reasonable to suggest that this thesis indicates a series of intersecting fields, where research may differ again in a year or two – in line with an ever changing and ever evolving culture and society. It may be an interesting step forward for one to conceive mental illness and culture as being inextricably linked, just like the relationship between the body and the soul.

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