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The Trail Back Home:

Wilderness Camping, Psychosis, and Hope

SUE STREIGHT

Have you ever been on a camping trip in the Canadian wilderness? While exploring remote trails and lakes, I've wondered how this amazing outback continues to exist through summer and winter, even though most of us don't give it a thought.

To me, the wilderness is like our mental health. Most of us don't give it even a fleeting thought despite the beauty it presents to us when things are going well. But when things go extremely wrong, and our mental world presents terror, we do pay attention. For example, a first episode of psychosis is often frightening, and treating the episode is an important narrative to recovering mental health and giving a future and a hope to young people and their families.[1] Your experience of a camping trip in the wilderness that had challenges, or the psychotic illness that took you to the emergency department, can have a lot in common when you feel ambushed by difficult circumstances that were unintended. Ultimately, though, within it is a model of recovery and optimism.

If you have ever packed for a wilderness out-trip for an extended number of days, you know that the person who plans your itinerary, packs the equipment, and designs the menu is invaluable. That person is an essential part of how your experience plays out—whether you bring a tent fly to protect you during the 48 hours of driving rain, whether you remember the matches for the fire, or whether you wish you had never attempted to discover if the wilderness was friendly. Occupational Therapists (OTs) and out-trip leaders have much in common. Let me explain.

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Welcome to the Summer 2019 edition of *Synergy*.

We're excited to bring you two articles by local mental health clinicians.

Our first compares the journey of someone experiencing the symptoms of psychosis to the challenges of embarking on a camping trip in the Canadian wilderness. Sue Streight is an Occupational Therapist with the Early Intervention in Psychosis Program at Hotel Dieu Hospital in Kingston. Her extended comparison is creative and illuminating, coming from a writer who has years of experience in supporting both patients with psychosis and campers in the woods. Her daughter, Evangeline Streight, is an accomplished artist and has contributed several original drawings to the article.

Our second essay synthesizes some of the recent literature on mental health and religion/spirituality. Anees Bahji is a senior psychiatry resident at Queen's University who is concurrently pursuing graduate degrees and conducting research in several fields.

We hope you enjoy the prose and, as always, welcome your comments.

SYNERGY SUBMISSION GUIDELINES

Synergy invites submissions from members of the mental health community in Southeastern Ontario and beyond. We encourage articles on current topics in psychiatry. Our essays are scholarly in outlook but not number of footnotes. We strive to publish good prose and ideas presented with vigour. Articles range from 500 – 1000 words. Longer articles may be accepted.

Articles may be submitted in the form of a Microsoft Word document as an email attachment.

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Prodrome

On a camping trip there are always signals that things are not going as planned before they actually go wrong. With an experience of psychosis we call this a prodromal phase. A majority of people who experience psychosis can be seen in retrospect to have a period in which they have some early manifestations: something is altered in their behaviour or thinking. Imagine the nervous feeling you have about your camping trip if you feel unprepared, have lost the map, or don't know the trail as you set out. These signs and symptoms, like the rain clouds piling up way too fast with your tent site still a portage away via a poorly marked trail with little rain gear to protect you, are prodromal features that you hope do not lead to a disastrous event. If your out-trip leader is not taking these signs into account, you start to get uneasy. An integral part of an early intervention into psychosis is being able to meet with an OT who can reflect back to you an early onset of causal events. This is invaluable in preparing, avoiding, or enduring the impending rain storm. The onset of psychosis is commonly known as an interaction between a stressor (inadequate gear or too much terrain to cover) and an underlying vulnerability (being exposed to the wilderness and the weather). The severe impact of the storm, which can completely thwart a trip, can sometimes be avoided by getting help early to avoid triggering larger consequences and a cascade of events.

Acute Phase

The acute phase of psychosis is characterized by features such as hallucinations, delusions, and disorganized thinking. Other coexisting conditions such as Depression, Obsessive Compulsive Disorder, Posttraumatic Stress Disorder, Anxiety Disorders, and Substance Use Disorders also may be present at this time and become more apparent with assessment. People suffering from these symptoms and experiences are often confused and traumatized by what is happening to them, not unlike the "my worst nightmare" camping trip. A camping trip that could have included at its heart untold beauty and the simplicity of nature is transformed by encountering a moose on your canoe path, or a bear that has discovered your food barrel. Panic can result in an immediate struggle to find the bear banger or light your bear flare or in anxious waiting in your canoe for that moose in your path to finish his wet lunch. This is like the disorientation of being ambushed by a psychotic episode. How you address the situation and the help and knowledge you have about it can change a situation from scary to manageable. The job of the OT at this stage (and the out-trip leader) is to educate and instill hope about how the difficult and scary circumstances can be managed and overcome.

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Assessment and a Service Plan

Having an OT/out-trip leader there for you to help assess the damage, maybe providing information on how to create a makeshift camp fly or recover food that has gone missing, is to commence a process of reducing the impact of the damage. Learning to set up an improvised fly for your tent out of that extra bit of poly-sheeting you brought along can be a lot like learning the right combination and coverage of medication. Believing in that protective layer of medication is often like believing you made the poly-sheeting tight enough and angled enough to run the stream of water away from the tent and not into it.

Assisting in minimizing the duration of active psychosis is the important job of your OT. Your OT can actively seek out resources and adaptations to the situation and provide education in areas you were not aware could affect you. Your OT may point out small areas for improvement in your sleep hygiene, your exercise schedule, or everyday structure and activities, which help recovery. Your OT may help manage seemingly impossible situations. Imagine forgetting your water purifier hanging on the tree at the last campsite before your last sweaty, mud-slogging, deer-fly-biting battle of a portage. Picture creating a sauna in the wilderness when you are chilled to the bone. Your out-trip leader/OT can help you.

The onset of acute psychotic symptoms is often the event that first brings a person into mental health services. When you are lost in the woods the most important reaction is to send or ask for help. Managing the acute problem directly in front of you (treating the symptoms), preventing further damage through providing a map that shows where the pitfalls may be in your journey (controlling substance use, sleep patterns, decreasing stress), and surviving the storm by laying a tarp properly, putting food in a bear-canoe, taking care of the blisters on your feet (laying the groundwork for psychosocial recovery) can make for a successful and completed camping trip. "With sustained treatment most patients eventually recover from their first episode of schizophrenia."[2]

Recovery

Recovery in psychosis generally has two phases:
(1) Early recovery (the first 6 months)
(2) Late recovery (18 months and beyond)

The focus at this time is on understanding the illness and learning to develop a range of skills that allow the person to attain their goals for the future.

This is the heart of the camping trip.

It is that point in the trip when you feel so far from civilization that you actually have forgotten what your life and even your house look like. At this time you need to understand how to build a camp-fire, how to go to sleep when the light fades, how to set a bear-canoe so that your food is safe, and how to follow the trails in a safe manner with your fellow trippers. You have learned how to use your whistle in emergencies, and have learned to dress in layers so you can peel off as the day gets hotter and the bugs become less intense. You are feeling comfortable in the wilderness and enjoying it with all its simplicity and beauty. Things are going well.

With the psychosis team you have learned how to take your medication consistently, how to use behavioural experiments to verify if that voice you are hearing is truly there, and how to use positive self-talk to deal with your ongoing beliefs—for example, that you are "a failure" because you were hospitalized. You may have become much more pro-active in getting enough sleep and avoiding stress-producing triggers, and you may have enough education from your camp leader to have decided that the brownies you packed for the trip were not going to get you feeling *high* in the forest, but more *lost*. (There is a higher risk of experiencing a psychotic outcome with cannabis use when compared to people who do not use, even after adjusting for socioeconomic factors, other mental health conditions, and personality.[3])

At this point in the trip, the role of your out-trip leader and OT is that they become less directive and more collaborative. Ownership is put on the campers to make good decisions based on what they know of the great outdoors and its unforgiving nature. In psychosis, this requires a more hands-off approach in which clients become responsible for their own recovery and gain insight about strategies that work or do not work for them.

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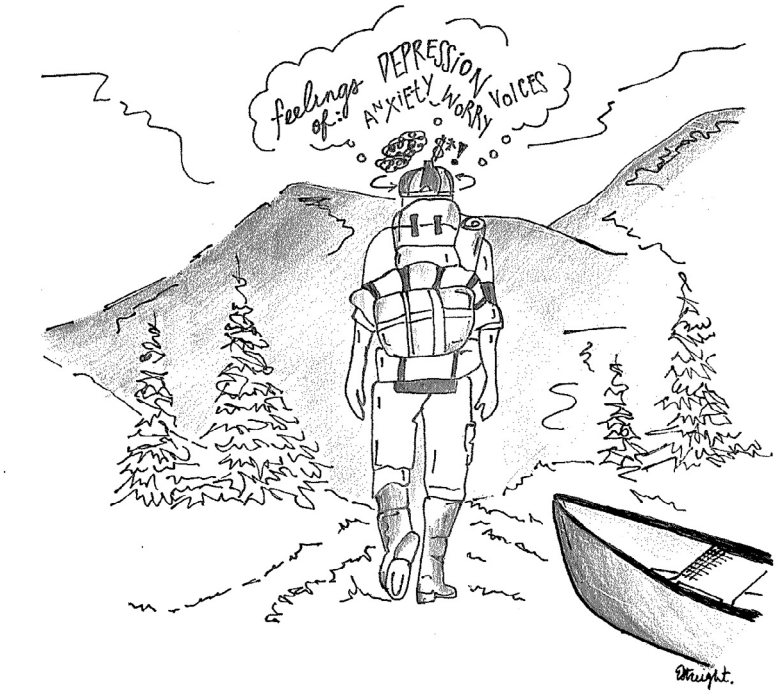
Relapse Prevention and Promoting Change

The idea of promoting recovery and preventing relapse is key, and yet sometimes the latter is inevitable. Let me take it back to the camping trip again. The example I have is the group who are 250 km up the river on their way to James Bay. One member has a serious food allergy that will cause havoc should he encounter this substance or willingly take it during the trip. Coming into contact with it without adequate forethought can trigger a cascade of events that require helicopter evacuation to safety and civilization. An evacuation while on a camping trip is a little like calling for a trip to the ER with a psychotic episode. And despite the best preparation, there are clients that end up in evacuation mode through relapse. It is sometimes caused by not fully appreciating that using substances or stopping medication have major consequences in any psychotic illness.

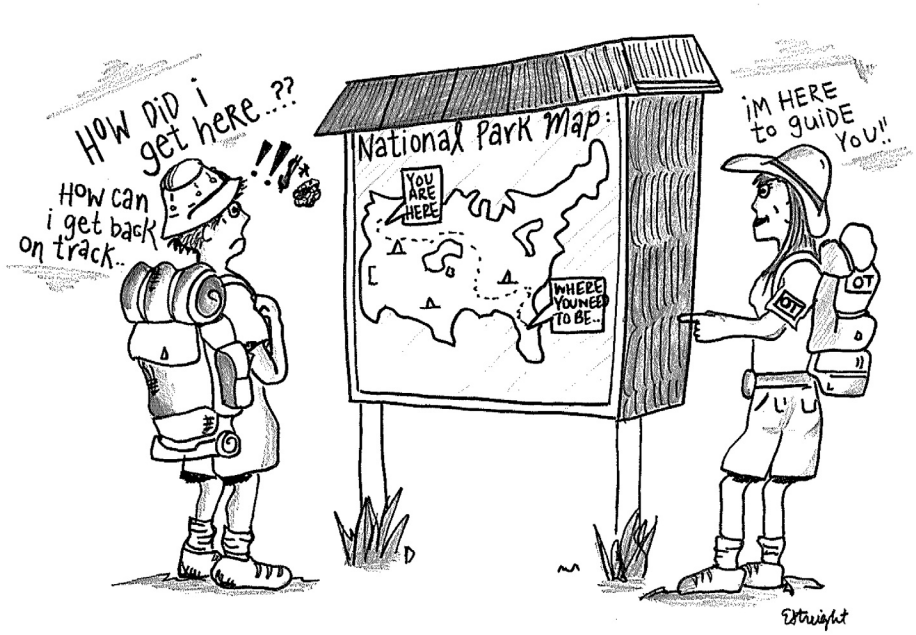
The intent of relapse prevention is to recognize the signs that something could potentially go wrong should we continue on the same course of action. Good out-trip leaders will see the signs of an impending disaster before it happens and do their best to avoid or mitigate it. They avoid taking unnecessary risks when weather patterns are volatile or circumstances become less predictable. The OT hopes to use good rapport, education, and the therapeutic relationship to change clients' ideas about lifestyle and to help them avoid future pitfalls by recognizing a problem before it happens.



Advocacy and Promoting Hope in Recovery

Ultimately, your OT is your advocate that helps you believe you can succeed, you can survive, and you can recover. My daughter once said this after 48 hours of drenching cold rain during a canoe trip: "If the sun does not shine tomorrow, I shall shed one tear in public and the rest in private". She needed to believe things would get better.

Ultimately, first episode psychosis becomes the responsibility of the entire treating team, just as the camping trip has many factors that ensure its success—from weather preparedness to the park ranger. Promoting ongoing healthy change, self-discovery, cognitive remediation, and coping strategies, as well as action towards ongoing health are the goals of graduating the client out of a first episode of psychosis program. Like the camping trip leader, as an OT I hope you have improved after having seen the beauty and terror of Mother Nature up close. Having a psychotic episode can cause you to take stock of yourself, identify your strengths and limitations, and put yourself into action. It does not mean your life is over. You must be willing to take the trail back home again. And having a supportive and compassionate OT who understands not only the empathy you need, but also the function you need in your life, can make all the difference.



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Delusion, Doubt, and Destiny: The Evolving Relationship between Religion and Psychiatry

ANEES BAHJI

For centuries, the relationship between religion, spirituality, and mental health has been controversial. Sigmund Freud and Jean Charcot famously reported that religion was the principal cause of neurosis,[1] while previous editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) portrayed various religious beliefs as delusional manifestations of severe and untreated mental illness.[2] Only a minority of modern mental health practitioners (39% of psychiatrists and 33% of clinical psychologists) identify themselves as religious.[3] And, in common practice, very few psychiatrists make use of religious or spiritual themes in their clinical practices.[4]

Is there potentially some truth in the perceived jests of Freud and Charcot? We know, for example, that certain psychiatric symptoms and mental states can convey religious content or themes. In depression, patients are frequently depleted of their zeal, while manic patients are often incensed, acquiring fervency and energy to the point that they experience delusions, sometimes of a religious nature.[5,6] In schizophrenia, patients may interpret auditory, visual, gustatory, olfactory, or tactile hallucinations as the voice, image, taste, smell, or touch of God, or even, Jesus. Some writers have gone so far as to question the crossroads of religion and psychosis, wondering if presenting complaints represent delusion or faith.[7]

Furthermore, it is well observed that certain drugs can alter our spiritual and religious experiences: *N,N*-dimethyltryptamine (DMT, "God"), 3,4-methylenedioxymethamphetamine (MDMA, ecstasy), psilocybin (mushrooms), lysergic acid diethylamide (LSD), and mescaline (*Peyote* cactus) have well-documented hallucinogenic, mind-expanding, and self-transcendent properties.

Even more remarkably, patients who are not particularly religious or spiritually-inclined at baseline can have profoundly religious experiences in the peak of a psychotic or manic episode (primary or induced). This finding in particular has led to the spawn of a novel discipline known as neurotheology—the combination of neurology, theology, and neuroscience, which has focused on attempting to identify the neural substrate of spirituality. In an editorial in *Psychiatric Times*, Dr. René Muller proposes that human beings are "hardwired for God," and that there is much to be learned about the physiological explanation of spiritual experience.[8] Many researchers have contributed to the field of neurotheology, exploring the various biological, genetic, and phenotypic avenues of spirituality. In his 2004 book, *The God Gene: How Faith is Hardwired into Our Genes*, Dean Hamer claims that a genetic polymorphism in the gene encoding vesicular monoamine transporter 2 (VMAT2)—an integral membrane protein that transports serotonin, dopamine, and norepinephrine—is the key to understanding spirituality.[9]

Hamer reports that the C/C variant (the so-called "spiritual allele"), which is present in 28% of individuals, is associated with higher scores on tests of self-transcendence and promotes higher consciousness. Although Hamer was unable to explain the precise reason why the C/C genotype was associated with higher spirituality, the C/C variant of VMAT2 was found to be more efficient at packaging and protecting monoamines from enzymatic degradation than the C/A or A/A genotypes, and, in so doing, seems to better control the flow of monoamines within the brain. Despite this finding, there is still no definite answer on how the brain is able to produce the contents of our conscious lives, including our spiritual experiences and religious beliefs.[10]

Despite this, one thing remains true: human beings, by nature, are not purely biological entities, but rather are multidimensional beings with psychological and social facets of existence. In psychiatry, we partially encapsulate this concept through the use of the psychiatric formulation, which often focuses on the biological, psychological, and social dimensions of existence. However, in the aptly-named "Prozac Era,"[11] we have often overlooked the spiritual components of our patients' presenting complaints, and have frequently downplayed their reliance on religious methods of coping. To date, prayer is one of the oldest and most commonly used forms of therapy, and has assuaged the suffering of the human mind far longer than any psychotropic medication, electrical stimulus, or surgical procedure ever has.

Researchers have probed further in various attempts at delineating the complex relationship between spirituality, religion, and diverse aspects of mental health. To date, this relationship has been a difficult one to elucidate for a variety of reasons. First, the concepts of religion and spirituality, although similar, are distinct entities: the former implies an institutionalized communal practice, while the latter indicates an independent, self-interpreted way of life that is often encapsulated in different ways in various religions. Second, the impact of religious ideology in different faith groups (e.g., Christianity, Islam, Judaism) has varying impacts on the mental health of their respective practitioners. Third, the types and kinds of research methods that have been (or should be) applied to studies exploring the relationships between religion, spirituality, and mental health are inherently different from the rigorous quantitative and qualitative methods applied to more traditional research topics; hence, their findings must be interpreted with some trepidation. And finally, what is the significance of such findings (if they exist), and how should they be implemented into clinical practice?

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In a recent review by Weber and Pargament, the mechanisms by which religion and spirituality impact mental health are extensively explored.[12] The authors conclude that religion and spirituality can simultaneously promote and damage one's mental health. Some studies indicate that religion and spirituality promote mental health through positive coping styles, enhancing the experience of community, improving access to emotional supports, and fortifying enriching beliefs that can enhance one's self-efficacy and resilience. On the other hand, the findings of several other studies have supported the opposing position—that religion and spirituality can be detrimental to mental wellbeing by promoting maladaptive coping strategies, engendering misunderstanding and miscommunication of mental illness, and suppressing the importance of having an individual identity. Hence, Weber and Pargament's findings are in keeping with an age-old adage: the context of one's religious and spiritual experience is just as important as the content.

As a result of a growing body of literature pointing to the importance of religion and spirituality in mental health, some practitioners have considered incorporating spirituality-focused content into psychiatric treatment. Others have explored the utility of clinical instruments that quantify the religiosity of patients, and which may be predictive of response to particular psychiatric treatments. A recent review identified more than 25 validated clinical instruments for obtaining a "spiritual history," with the authors finding that the act of taking a spiritual history may itself improve patient compliance with treatment, satisfaction with care, and health outcomes.[13]

Concurrently, there has been an upward trend in the integration of religious and spiritual themes into medical education, particularly in the field of psychiatry.[14] This trend has been backed by the Association of American Medical Colleges (AAMC), which has recommended that spirituality be addressed in medical curricula.[15] Over time, the proportion of the 126 accredited US medical schools offering courses in spirituality and medicine has increased from 17 in 1994, to 39 in 1998, to 84 in 2004. Currently, over 100 medical schools in the USA offer courses or seminars on spirituality and medicine.

The Canadian medical education system may soon follow suit, with an increasing number of calls for training in the provision of "spiritual health care".[16] In a self-reflective piece, family physician Dr. Sharon Hatcher writes how medical education and practice are undergoing a process of renewal—triggered by chronic disease, aging populations, and rising costs of care.[17] She adds that there

is increased interest in holistic approaches, which have included more discussions about the role of spirituality in patient care.[18] Psychologist Dr. Patricia Mcilvride has suggested that defining the mind as "transcendent and both embodied and relational" will enable new avenues of recovery and healing in mental health, particularly in combatting self-stigma.[19] Author Dr. Rhett Diessner has proposed that neuronal firing is responsible for virtuous behaviour through an "act of will": this then creates a feedback loop in which those same virtuous deeds further influence one's brain patterns, which can then influence cognitions and emotions in the mind, and eventually, the soul.[20] In some ways, Diessner's proposal is a spiritual analogue of Beck's cognitive triad, which emphasizes the interconnectedness between emotions, thoughts, behaviours, and cognitions.[21]

As such, incorporating a spiritual conceptualization of the mind may have significant benefits for our ability to provide care to a diverse patient population. Author Michael Penn writes about how the Bahá'í Faith—one of world's newest religions—conceptualizes the mind as a spiritual construct, which has implications on the practice of psychiatry and psychotherapy.[22] According to Bahá'í scripture, the mind is an "epiphenomenal by-product of the composition of the human brain and body": it is not directly knowable, and is produced by the presence of the soul.[23] Penn surmises that "the mind is not a passive recipient of the forces that operate upon it", adding how the Faith—which has historically praised the work of Aristotle—asserts that to know the true identity of a thing, we must first knows its four causes—material, formal, efficient, and final.[24]

Bahá'í psychiatrist, Dr. Abdu'l-Missagh Ghadirian, has written extensively on how the spiritual insights afforded by Bahá'í scripture can enhance our understanding of the diverse causes, treatments, and risk factors for depression.[25] Dr. Ghadirian argues that the inclusion of spiritual dimensions in psychiatric practice may not only enhance our understanding of depression and other psychiatric illness, but also their treatments, particularly in the significant role that stigma plays.[26]

In traditional Bahá'í scripture, the bird is symbolically used in the depiction of a variety of concepts—the equality between men and women, and between religion and spirituality. Perhaps, then, it would not be too far of a stretch to apply this concept to the complex relationship between religion and mental health: despite the centuries of debate, we cannot deny the powerful influence that these forces continue to have in modern psychiatry, and the eternal struggle for balance that is required for the bird of humanity to remain aloft.

Anees Bahji, MD is a fifth-year psychiatry resident at Queen's University with recently-developed interests in spiritualism and religiosity within mental health.

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