GROUP 2. Perspectives on the internal: cell mechanisms, neurophysiological and psychological aspects

Spiritual distress: mental health and spiritual health

Background:
Once a diagnosis of a serious and potentially fatal disease has been pronounced, spirituality can no longer be just a theoretical concept. The search for meaning becomes more acute and it has to deal with dependence, loss of identity, a sudden shortness of time and uncertainty about the future. We can therefore talk about a spiritual crisis.

Western spirituality:
In the West, spirituality is defined as man's search for meaning and the purpose of existence. This search may be based on beliefs, religious or otherwise, or on a philosophical, moral, artistic or scientific attitude. It may involve practices and rituals. It is part of man's natural development. Meaning, values and transcendence allow the patient to define him/herself spiritually.

Psychiatry and mental health:
Psychiatry, as a branch of medicine, and, alongside it, the field of mental health, developed more than one hundred years ago in the West in a clinical and scientific context with neurobiological and scientific bases that locate the origin of mental experiences in the activity of the brain. In the light of the separation of faith and science in the modern western world, psychiatry is not interested in aging and death from a spiritual or religious point of view but leaves this to hospital chaplains as part of the charitable tradition taken on by the Church.
Point of view of patients:

However, in Switzerland, as in Europe and the United States, most people who are asked define themselves as spiritual or religious. In the event of a serious illness, the majority or patients would prefer to have a doctor that was spiritually in tune with them. Furthermore, numerous studies have demonstrated that spirituality has a favourable impact on both physical and mental health.

Issues

However, in spite of this evidence, doctors and, in particular, psychiatrists regularly ignore spiritual and religious factors in their practice and research. Indeed, psychiatrists are less religious than the general population and tend to see religion as leading to feelings of guilt and dependence and as being associated with superstition and intolerance. However, thanks to recent progress in the neurosciences, doctors have started to take an interest in the cerebral circuits involved in spirituality and religion, as well as in the work showing the beneficial effect of spirituality on anxiety and mood disorders and addictions.

These recent developments show that there is a difference between mental health and spiritual health, with significant interactions between the two. This means that we should be offering care for spiritual distress in addition to the usual mental health treatment.

Points for discussion and questions:

However, this need raises ethical problems for healthcare professionals, doctors and psychiatrists: What are the legitimate grounds for their offering patients spiritual interventions and for their stepping outside their medical and scientific expertise? Is there not also a risk of upsetting the patient, for example, by inducing a sense of guilt for his or her spiritual failing or by intruding into his or her privacy? What kind of interdisciplinary practice should be established between the medical world and the spiritual and religious world?

Denial of death and belief in the power of science and technology

Summary

The modern, advanced, western world is characterised by a growing refusal to accept limits, whether they concern our mental or physical performance or our inevitable aging. This refusal can go as far as the denial of our need to accept our own mortality. This situation owes much to the development of technologies and the progress in medicine and biology that have led to a continuous rise in life expectancy in rich countries – a process that began at the start of the 19th century and accelerated into the second half of the 20th century. Since it is possible to attribute

---

29 In this section, I discuss several ideas inspired by Céline Lafontaine's book, La société post-mortelle, Paris, Le Seuil, 2008.
the cause of death to one of a growing number of biomedical factors (microbial, molecular, genetic), it seems that, in this day and age, we do not really die, we just die of "something" that it is possible to control. In this context, the field of biomedicine has become a genuine battleground against the causes of death. Death and old age have therefore become the last diseases to be eradicated. Now that old age is no longer a cause of death, we are entering an age of "postmortality" where there no longer seems to be any theoretical limit to the extension of human life.

According to some views and predictions on the continuous process of overcoming the limitations and vulnerabilities of the human body and following an engineering approach applied to biology, all that is needed to achieve a form of amortality is to identify the barriers that need to be overcome to eliminate the aging process (blocking molecules that damage cells, controlling cell death, repairing DNA, gene and cell therapy, etc.).

The transhumanist movement that emerged at the end of the 1990s and the Singularity University, created in 2008 on the site of the NASA Research Park in the heart of Silicon Valley, embody this trend to an extreme degree. Bringing together researchers, engineers, entrepreneurs and financiers, this discussion grouping predicts a radical "improvement" in human beings that will result in "post-human" beings, freed from biological limitations. It supports a quest for amortality or immortality which starts with anti-aging, moves on to interfacing the body with machines, in particular computers (cyborgisation), and the cryopreservation of dead bodies in the expectation of regeneration, and ends with the ultimate aim of uploading ones conscience into a computer memory – the equivalent of immortality. Neurosciences and the nano-bio-info-cogno (NBIC) convergence fuel the central core of these promises.

It is as if people were seeking to actively take over biological evolution, now judged to be too slow, so as to radically "improve themselves" as part of a scientific and technological programme. People seem ashamed of their own mortal condition compared to the potentially perfect and immortal machines that they have been able to produce. In a world dedicated to the cult of achievement, growth and continuous acceleration, humans, in their mortal and biological condition, now consider themselves obsolete. In such a context, the old and the dying seem like losers in the face of future scientific and medical victories yet to come. The "social death" of the elderly, increasingly isolated from their families and judged useless and uneconomic, unfortunately often precedes their biological death by several years.

The amortal human being represents a secular and scientific version of the ancient quest for immortality characteristic of all societies. It is the cultural expression of an all-powerful society of Reason where the expectation of resurrection or reincarnation has been replaced by an (irrational?) belief in continuous scientific and technological progress. This pattern of denying death and finiteness cannot be appreciated without considering its flip-side: the environmental crisis and the awareness of the inescapable finiteness of the biosphere – at least as far as human habitation is concerned. While the major religions tend to stress the primacy of the spirit, the soul and of spirituality over the biological body, the techno-scientific vision of a post-mortal society is concerned above all with controlling and repairing the human body, from plastic surgery to cell or gene therapy.
The scientific and medical establishments carry a heavy responsibility in these matters because it is on them that these promises of technological control and amortality rely.

**Topics for discussion**

Against this background of denial of death and the cult of youth and achievement, is it possible to reconcile respect for human beings, in particular the old and the most vulnerable among us, with promises of amortality and human “improvement”? How do we accept our finiteness while continuing to treat the ill and combat disease so as to be able to live and die peacefully?

In a world where social inequalities never cease to grow, and against a backdrop of increasingly scarce resources and growing damage to the environment, how do we reconcile our desire to control without limit with an acceptance of our finiteness?

**Definition of death and its implication**

Defined by cardiopulmonary arrest, observable by loved ones, death is currently located in the complexity of physiological processes. The Swiss Academy of Medical Sciences summarises its key elements.

“A human being is dead when all the functions of the brain, including those that keep the body alive, have ceased irreversibly. Through the irreversible failure of cerebral functions, a human being irrecoverably loses the central organ of his or her organism. This is followed by the inevitable death of all the body’s organs, tissues and cells.

*Death can be due to the following:*  
*a primary attack of the brain causing irreversible failure;*  
*a persistent circulatory arrest reducing or interrupting the circulation of blood long enough to cause irreversible failure of the brain and hence death.*

The observable phenomena and the signs that clinicians look for are interpreted together as proof of death: coma, various ocular signs, absence of cerebral reaction to painful stimuli, absence of cough reflexes and those of the throat, absence of spontaneous respiratory activity.

**And after death?**

After death, different biological processes break down the tissues and cause the body to decompose. When contemplating a corpse or human remains, we cannot help but be confronted with the finiteness of human life as we know it. For many of us, this raises the issue of life after death, often in the form of resurrection or reincarnation. From a biomedical perspective, an experimental approach, as used in research, cannot be adopted in relation to either form. In the Christian context, life after death is enshrined in belief; in the Buddhist context in a lived experience.

---

30 Determination of death in the context of organ transplantation. Medico-ethical guidelines, Swiss Academy of Medical Sciences, 2011: citation from the text in italics.
Defying death?

Today, technical advances make it possible to compensate for the failing functions of certain organs and hence to prevent (immediate) death. Artificial respiration and extracorporeal circulation can therefore maintain favourable conditions for the functioning of the brain. Conversely, in certain situations, the organs can continue to function even after brain death, leaving the patient in a coma. Long believed deprived of brain function, patients in a vigil coma (or vegetative state) may retain islets of brain function.

Organ donation

The feasibility of organ transplantation has led to a more precise definition of death. Defining when it is correct to envisage the removal of an organ is not just a biomedical but also a legal and ethical matter. Apart from the technical challenge it represents, organ transplantation has a societal significance: the death of one person can prolong the life of another.

Experiencing death as a way of becoming aware of death and managing the anxieties it causes

Foreword

The point of departure is the reflection by His Holiness the Dalai Lama in *The Universe is a Single Atom* (2005), which deals with the connections between Western and Buddhist knowledge (philosophy, epistemology, psychology). In order to enter into a dialogue with His Holiness the Dalai Lama, we propose to approach these connections through the example of experiences with near-death. At the heart of the discussion are the ways in which these experiences are shared (narratives) and explained (evidence) by scientists or mental health practitioners. The issues of whether death education must be by way of experience and to what extent the person who has experienced death, at least near-death, can be considered a teacher of death will be raised.

Preparing for death

In the Christian tradition, individual preparation for death is the desired condition for passage to the afterlife: by witnessing various instructions, such as that of the *ars moriendi*, of the *Death of Ivan Ilich* of Leon Tolstoy, or of the *Death and Dying Seminars*. In the latter, the psychiatrist Elisabeth Kübler-Ross prepares her patients at the end of their life to separate themselves from various bonds so as to accept approaching death.

On the other hand, there is also a Western philosophical tradition which focuses on the beneficial effects of an unexpected and sudden death. Michel de Montaigne is without doubt one of its most well-known proponents: the philosopher put down in writing his contemplations on death after falling from his horse, when he believed that he had died without experiencing a frightening thought or any pain. In “That to Philosophise is to Learn to Die”, Montaigne encourages his readers to meditate constantly on death so as to reduce their anxieties towards it: “We do not know where death awaits us, so let us wait for it everywhere. To practice death is to practice freedom”31.

---

Limit-experience and salutogenesis

Since the 1970s, near-death experience (NDE) has been very successful thanks to the autobiographical publications of survivors of heart attacks, difficult operations and accidents. It has been the subject of scientific studies and is at the heart of discussions about evidence of the survival of the soul after death and the conflictual relationships between medicine and spirituality.

The scientific approaches currently proposed to explain this “limit-experience” are:
- the neurological approach: NDE results from a dysfunction in visual perception located in the temporo-parietal junction;
- the psychopathological approach: NDE is the expression of a psychopathological disorder (heautoscopy, for example) or of an emotional reaction to a threat (theories on psychological trauma);
- the neuroendocrinological approach: NDE is produced in the absence of oxygen or when a shock occurs through the effect of an overproduction of endogenous molecules (opioids or DMT (dimethyltryptamine));
- the parapsychological approach: NDE is the expression of extra-sensory perception comparable to telepathy and clairvoyance;
- the psychological/spiritual approach: NDE results from a psychological need which induces a cathartic effect in the individual. This salutogenic approach attributes a power of transformation to the experience: the individual is transformed following the experience and significantly changes his or her attitude to life and death. The salutogenic approach distinguishes NDE from delirium and pathological reaction.

Testimonies: the narrative of a life and the life of a narrative

In the corpus of Western narratives on sudden near-death experiences, at least since the mid-19th century a number of characteristics described by the survivors, or those who have returned from the hereafter, are repeated: a feeling of bliss, the absence of pain, the lamentation of innumerable images. These images often appear rapidly and retrogressively to the individual in danger, who sees scenes of his or her past life and experiences joyful and sometimes painful memories. One of the most famous narratives is that of Albert Heim, a Swiss mountaineer who, in 1892, published an account of a fall he had in the Alps:

"Then I saw my whole past life take place in many images, as though on a stage at some distance from me. I saw myself as the chief character in the performance. Everything was transfigured as though by a heavenly light and everthing was beautiful without grief, without anxiety, and without pain. The memory of very tragic experiences I had had was clear but not sadening. I felt no conflict or strife; conflict had been trasmuted into love"32.

This narrative, partially cited here, recounts the stages of a life, but it also has its own life. Even now, countless researchers refer to this narrative in order to illustrate a near-death experience.

Themes for discussion

It seems that the Western tradition has a predominant relationship with the narrative as

evidence of an experience. This holds for practitioners not only in the fields of nursing, religion and psychology, but also in the exact sciences, who, in their experimental studies, analyse testimonies in the first person in order to explain the limit-experience. What about the Buddhist tradition and its relationship with the narrative?

What is the role of the “knower” of death in the Buddhist tradition (Rinpoche) in comparison with that of individuals who have had a spontaneous, sudden and unprepared near-death experience?

With the *Bardo Thödol*, the Buddhist tradition has an exemplary instruction for passage to the afterlife. This book was acclaimed, and still is, by Western psychologists striving to integrate the spiritual experience into psychotherapeutic practice (C.G. Jung, Stanislav Grof). The notions of *death and rebirth* (Grof) or *egocide* (David Rosen) employed in transpersonal psychology imply that patients must pass through a state of self-annihilation before they can accept themselves in their new existence. Must one “die” to know oneself, even if symbolically? And to what extent does “victory” over one’s anxieties towards death require one to “mimic” one’s own death?