Lisa Miller

The Awakened Brain

The Psychology of Spirituality

'A captivating look at what happens when we're connected to something greater than ourselves'

ADAM GRANT

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PENGUIN BOOKS

The Awakened Brain

‘Truly transformative ... Lisa Miller’s life’s work and story weave a tapestry of science, psychology and spirituality which unfolds a world of mystery and meaning ... reveals a unity to the universe that can be accessed by both heart and mind for our mental and physical well-being’ The Rt Revd James Jones KBE, author of *Why Do People Suffer?*

‘Potent, profound, and accessible ... a compelling examination of the correlations between spirituality and mental health’ *Kirkus Reviews*

‘Unequivocally shows that spirituality heals. Her pioneering research has vast implications not only for medical science, but also for the growing field of consciousness research’ Larry Dossey, author of *Healing Words*

‘Fresh research by Lisa Miller reveals a clear link between spirituality and our mental well-being’ *The Tablet*

‘Miller’s pioneering work has shown both that spiritual feeling guards against depression and anxiety, and that this sense of presence can be measured in brain studies ... Miller argues that spiritual awareness is to be found across religious differences and should be considered a birthright’ Mark Vernon, *Church Times*

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To Phil, with love

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Never cease to stand like curious children before
the Great Mystery into which we were born.

—Albert Einstein

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one percent of American adults will develop a full-blown anxiety disorder at some point in their lives, and 19 percent in any given year.[2] The World Health Organization reports that 264 million people on the planet are depressed; depression is the third most costly disability worldwide.[3, 4] Each year, 17 million American adults are depressed. Over 16 percent of youth in late adolescence currently face depression, and the impact of depression on suicide accounts for *the second leading cause of death* in adolescents, rivaled only by death by auto accident.[5, 6]

At Columbia University, where I teach, eight students died by suicide in 2016–2017. A study of more than 67,000 college students across 108 institutions in the United States published in 2019 found that *20 percent* reported that they had engaged in self-harm such as cutting, *24 percent* reported suicidal ideation, and *9 percent* had attempted suicide.[7]

While the stakes of our mental health crisis are truly life and death, many of us also suffer from less debilitating, though still painful, conditions: burnout and chronic stress; trouble concentrating and connecting; loneliness and isolation; lives that are rich in many ways yet feel somehow narrow, hollow, and cut off. Even when we experience success and satisfaction, we may sense that there's more to happiness—that life could be more joyful, rewarding, and meaningful.

It seems that every person I meet has a parent, child, sibling, partner, or close friend afflicted by depression, anxiety, substance abuse, or chronic stress. And there's not a lot on offer for those of us worried about a loved one, or struggling ourselves. Our mainstay treatments for depression—psychotherapy and antidepressant medications such as SSRIs—provide some help to people, but for others have disappointing results. Only *half* of treated patients see a disappearance of symptoms within a year of intervention, while another 20 percent find only a partial reduction of symptoms; and the positive effects that are gained through medication are not enduring—when we stop taking the drugs, depression or anxiety often returns.[8]

I hoped that today's lab meeting might reveal even an inkling of a sustainable solution to our devastating crisis in wellness and

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mental health. Ravi followed me into a crowded room and we squeezed into the last two open seats around the long wood laminate table. His fingers drummed the stack of papers.

He usually worked with a detached, skeptical cool. “We can run the data from the scanner,” he’d said, “but I seriously doubt we’ll find anything.” Myrna, the MRI team’s most senior colleague and the one who had secured the funding for this study, had agreed, saying, “I’d be *very* surprised if we find any kind of association between spirituality and depression, but we shall see.”

Contemporary psychotherapy tended to characterize spirituality and religion as a crutch or defense, a set of comforting beliefs to lean on in hard times. In our field, spirituality was a barely studied, nearly invisible variable. Over the past twenty years of my career, I’d seen surprising clinical and epidemiological evidence that spirituality could have a protective benefit for our mental health. But could we discern a concrete physiological function of spirituality in our health and development? Was spirituality thus far invisible in the brain because it was insignificant to mental health or impossible to measure—or was it invisible because no one had yet looked?

Myrna cleared her throat and started the meeting.

“Let’s take a few moments to review the initial MRI findings,” she said. “I believe Ravi’s compiled a handout with the new results.”

Our team had used Myrna’s multigenerational sample of clinically depressed and non-depressed women, and their children and grandchildren. We’d taken MRI scans of people at high and low genetic risk for depression to see if there were any patterns among the brain structures of depressed and non-depressed participants that could allow us to develop more targeted and effective treatments.

And we’d added a new—and controversial—question to our study. We’d asked all participants to respond to a major question used in the clinical science literature to quantify inner life: *How personally important is religion or spirituality to you?* In addition to comparing the brain structures of depressed and non-depressed candidates, we wanted to see how spirituality was associated

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with brain structure, and how spirituality correlated with risk for depression.

Ravi's face still looked stunned and his hands jittery as he passed his stack of papers around the room. I took a two-page color handout from the pile. It was still warm from the printer. My eyes raced over the page, taking in the results, looking for whatever it was that seemed to have rattled Ravi. It took only a moment for me to see it.

On the top half of the page was a black rectangle with two brain images inside. The scan on the left showed the composite brain image of participants with low spirituality—those who had reported that religion or spirituality was of medium, mild, or low importance. The scan on the right showed the composite brain of participants with sustained, high spirituality—those who had said religion or spirituality was of high personal importance.

The difference between the two images made my heart race and my spine tingle.

The brain on the left—the low-spiritual brain—was flecked intermittently with tiny red patches. But the brain on the right—the brain showing the neural structure of people with stable and high spirituality—had huge swaths of red, at least five times the size of the small flecks in the other scan. The finding was so clear and stunning, it stopped my breath.

The high-spiritual brain was healthier and more robust than the low-spiritual brain.[9] And the high-spiritual brain was thicker and stronger in *exactly the same regions* that weaken and wither in depressed brains.

The room was utterly silent.

"It's not at all what we expected to see," Ravi said.

The air conditioner clanked on, a loud roar amid the stillness. Then a low chuckle rose from the back of the room.

"Well, well, Lisa," someone said.

My closest, most treasured colleagues had been skeptical. But the data was persuasive. Spirituality appeared to protect against mental suffering.

THE MRI FINDINGS marked a pivotal moment on the way to my breakthrough discovery that each of us has an **awakened**

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brain. Each of us is endowed with a natural capacity to perceive a greater reality and consciously connect to the life force that moves in, through, and around us. Whether or not we participate in a spiritual practice or adhere to a faith tradition, whether or not we identify as religious or spiritual, our brain has a natural inclination toward and docking station for spiritual awareness. The awakened brain is the neural circuitry that allows us to see the world more fully and thus enhance our individual, societal, and global well-being.

When we awaken, we feel more fulfilled and at home in the world, and we build relationships and make decisions from a wider view. We move from loneliness and isolation to connection; from competition and division to compassion and altruism; from an entrenched focus on our wounds, problems, and losses to a fascination with the journey of life. We begin to live beyond a "pieces and parts" model of identity and a splintered, fragmented view of who we are to one another, and to cultivate a way of being built on a core awareness of love, interconnection, and the guidance and surprise of life.

I didn't set out to study spirituality per se. My discovery of the awakened brain began with a desire to understand human resilience and help people who were struggling. Bit by bit, striking data points and my patients' stories of hurt and healing helped me see that spiritual experience was a vital, though overlooked, component of healing.

So what is spirituality? Many of us have had experiences we might describe as spiritual. A moment of deep connection with another being or in nature. A feeling of awe or transcendence. An experience of startling synchronicity or a time when a stranger showed up and did something that changed your life. A time you felt held or inspired or buoyed up by something greater than yourself—a higher power perhaps, but also nature or the universe or even the surge of connection at a concert or sporting event.

I'm a scientist, not a theologian. Faith traditions have a lot to say about ontological questions—the nature of reality, why we're here, the existence and guidance of God or a higher power. As a

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scientist, I don't address these issues. I look at how humans are built and how we develop over the life span.

I've discovered that the awakened brain is both inherent to our physiology and invaluable to our health and functioning. The awakened brain includes a set of innate perceptual capacities that exist in every person through which we experience love and connection, unity, and a sense of guidance from and dialogue with life. And when we engage these perceptual capacities—when we make full use of how we're built—our brains become structurally healthier and better connected, and we access unsurpassed psychological benefits: less depression, anxiety, and substance abuse; and more positive psychological traits such as grit, resilience, optimism, tenacity, and creativity.

The awakened brain offers more than a model for psychological health. It gives us a new paradigm for being, leading, and relating that can help us act with greater clarity and capability as we face humanity's greatest challenges. We can evolve our work and school culture toward greater purpose and meaning. We can revise our governments and health and social service institutions to better support and serve all. We can see our choices and the consequences of our actions through a lens of interconnectedness and shared responsibility. And we can learn to tap into a larger field of awareness that puts us in better touch with our inner resources, with one another, and with the fabric of all life.

An awakened brain is available to all of us, right here in our neural circuitry. But we have to choose to engage it. It's a muscle we can learn to strengthen, or let atrophy. I've come to see the problems we have in leadership, education, social justice, the environment, and mental health as different emanations of the same problem: *un*awakened awareness. A universal, healing capacity that has not been engaged or cultivated, that's been left to die on the vine. The problem is within. And so is the solution.

Each one of us has the ability to fully develop our innate capacity to live through an awareness of love, interconnection, and appreciation of life's unfolding. Beyond belief, beyond a cognitive story we tell ourselves, the awakened brain is the

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This wasn't a top-choice hospital—patients with good insurance often went elsewhere—but it wasn't a final stop, either. To come here wasn't the equivalent of being "sent upstate," the euphemism many medical staff and patients used to refer to a long-term mental illness facility in northern New York. Yet all of the patients I'd met here had been admitted and readmitted numerous times, their files three or four inches thick. I was one of four interns on the ward, each of us serving two residents at a time, as well as a caseload of eight through our outpatient clinic. We started each day with a team meeting at eight o'clock sharp, the staff of psychiatrists, psychologists, social workers, nurses, and aides gathering around a table to hear updates from the night before—what the patients had eaten, how they'd groomed and slept, if there'd been any behavioral episodes. "Mr. Jones was malodorous," an aide would report. "Ms. Margaret refused dinner." Basic health and grooming habits can be tied to aspects of mental health—yet it always struck me as odd that on a ward dedicated to the healing of inner struggle we spent so much time talking about the physical body. Most patients wore hospital gowns, not street clothes, as though they were at the hospital for surgery or for treatment of a physical illness that required them to stay in bed.

I'd noticed the same phenomenon the first time I set foot on a psychiatric ward in the mid-1970s, when I was about eight years old. My beloved Grandma Eleanor, who had commuted back and forth from Iowa all the way to the University of Chicago to study psychology, took me to visit her dear friend who'd been hospitalized, someone she'd grown up with and stayed close to over the decades. The friend was not actually related to me, but I'd always known her as Aunt Celia. In the hospital, I was confused to discover that she didn't appear to be sick. She wasn't wearing any bandages that I could see. She wasn't hooked up to any machines. She had a radiant smile, a knowing sense of humor. And yet, like the other patients on her floor, with pain visible in their faces, or eyes gone distant, she was confined to a narrow bed in a small room. I was struck by the suffering I sensed in many patients there, and by how isolated Aunt Celia and the others appeared. Later, I would learn that Grandma Eleanor was

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known for a legacy of activism, working constructively with state hospitals to bring psychotherapy to patients in institutions where they were only being injected, or put in straitjackets, or given shock therapy, and that she advocated for patients like Aunt Celia to be moved to eldercare homes where they could receive ongoing medical attention while also enjoying a greater sense of community and support.

In many ways, mental health treatment standards had considerably improved in the twenty years since I'd visited Aunt Celia. The thirty-five patients on Unit 6 weren't restrained in straitjackets, or locked up and forgotten. We operated as a therapeutic community, patients participating in large and small psychotherapy groups each week, as well as short daily check-ins with their assigned doctor. The residents could move freely on the ward and engage in conversation or activities in the community room. The staff had top-notch training and cared deeply about the patients.

Our psychological treatment model was primarily psychodynamic. We'd been trained to help patients comb the past for insights and awareness that could release their present suffering. If patients could understand their anger or childhood wounds, the theory went, they could release them and no longer be controlled by them. The way out of suffering was to face suffering and gain insight. To excavate painful memories and experience discomfort in order to advance awareness.

On the psychiatric side, the ward took a psychopharmacological approach, using medications to ameliorate or eradicate symptoms. I was grateful for the medications that provided relief to patients in acute pain. Yet in my first weeks on the ward I began to wonder if we could do more to support patients' long-term healing, to interrupt the constantly revolving door between in- and outpatient services.

After the morning team meeting, the interns would go see our individual patients, stopping by their rooms or finding them on the unit to see how they were doing. I wondered what it was like for patients in their forties, fifties, sixties, and older, who'd suffered for decades, who were on their sixth or seventh admission to the ward, to have a twenty-six-year-old intern

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who'd been practicing for all of three weeks show up unannounced for a twenty-minute conversation, the young intern in professional clothes, the seasoned patient in a flimsy, open-backed gown, knowing the whole process would begin again in six months when the current batch of interns left to begin their next rotation. Did we really know more about the nature of our patients' suffering than they did themselves? Might there be a different path? A way to analyze and pathologize less, and hear more?

As summer bent toward fall, the more frustrated I became with an approach that seemed unhelpful at best, and, at worst, a tragic dead-end. We could offer a temporary, medication-induced reprieve from painful symptoms, or a slightly better understanding of why a childhood trauma had been so derailing. Neither outcome promised real healing. And when a patient opened up with an authentic expression that didn't quite fit our psychoanalytic mold, we sometimes shut the door.

I co-led a weekly group with a fellow intern who had a strong, verging on inflexible, theoretical view. He thought the purpose of group psychoanalysis was to interpret and release our projections. He wanted patients to interpret what they made of one another and see how they misunderstood one another as projections of their injured psyches. One week a woman who was diagnosed with schizophrenia stepped outside the choreography. "I love to pray," she said, "but when I'm having symptoms and I try to pray, I don't hear my prayers the same way." I turned toward her. "Wow," I said, leaning in, inviting her to say more. But the other intern cut her off. She tried to speak again and he waved his hand impatiently, dismissively. The room grew quiet. "So you see me as what?" he said. "A bully? Do you see me taking control?" Somehow the patient was supposed to figure out he wanted her to interpret how she saw him as a projection of a feeling or experience from long ago. To this day I regret that I didn't push back and hold space for the patient. That I didn't turn to her and say, "What were you saying about your prayer life?" I decided I would never let the door be closed on patients again. That if they opened a door, I would hold it open.

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It sometimes seemed that instead of helping patients get better, we were making them worse. Reinforcing a burden. Handing them a deterministic perspective. Teaching them that the sum of their lives would never amount to more than the effects of whatever terrible, inescapable thing might have happened in the past. That the best they could hope to achieve was a clearer understanding of how they'd suffered, and of how their suffering had written the rest of their lives. The bulk of our patients returned to the ward multiple times over the course of decades, one psychoanalytic therapist after another helping them construct a more and more entrenched narrative of how they had been broken by what had happened when they were young.

One of my first patients on the ward was Mr. Danner, a man in his mid-fifties with a wardrobe of bell-bottoms and leather jackets and feathered hats straight out of the 1970s Harlem nightclub scene where he'd dealt and become addicted to heroin as a young man. Almost all of his friends from that time were dead. He was still using, his legs, arms, and neck riddled up and down with pockmarks from shooting up. He'd been admitted to the ward so many times for aggressive behavior and delusional psychotic outbursts over the last twenty years that his file included two folders, each one five inches thick.

He was fifty-six, but he looked eighty-six, his body hollowed out and hunched, his jutting shoulder blades sharp and pinched through his shirt. He walked with a cane, one of his legs almost too stiff to move. His uneven hair, shadowed face, and unwashed clothes reinforced the impression of his deterioration, but in his square jaw and expressive light brown eyes I could also see a glimpse of the man he'd been, his good looks and swagger.

At our first session he cut straight to his childhood trauma. "It was a cold winter in North Carolina," he began. "I was four years old and I was staring into my mother's coffin."

I was moved by his story of wrenching loss, of being shuttled from relative to relative after his mother's death, landing in New York as a young teen, chasing after parties and drugs as though still trying to warm the chill of that indelible winter day.

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When we met a second time, he started our conversation the same way. "I was four years old and I was staring into my mother's coffin." Again, on our third visit, the same story, sad and haunting as ever, but told in a way that seemed increasingly rote and dissociated, as though he were fulfilling an obligation. I looked back through the earliest entries in his file and discovered the same early childhood memory referenced on page after page of clinical notes. Through decades of treatment he'd kept reliving the same cold, bereft moment. And it seemed in some ways that his therapy on the ward had reinforced his living there. Round and round through the revolving door of his admissions and discharges and readmissions, he'd been asked the same questions by each new intern. How did he feel about that moment? What were his insights about that moment? He'd been trained to fixate on that memory, but when he talked about it, it didn't seem full of his current psychological energy.

I started asking him questions outside the psychoanalytic mold. "How are you doing *now*?" I'd ask. "What happened this week? What's new?" Questions that brought him back into the present. He'd adjust himself, sit up straighter, reposition the cane he held between his legs, and lean forward, looking me in the eye.

"I rode the subway one day, a few years ago, right next to a woman in a fur coat," he said on one visit. "We made small talk. She didn't know the whole time I was sitting there I had a gun under my coat, that I was off to do something bad."

A psychoanalyst is trained to meet this kind of remark as a challenge, to take back control, to say, "Are you trying to rile me?" But each time he told me about a bad thing he'd done—and he had done cruel things, committed armed robberies, slept with his wife without telling her he was HIV-positive—I got the sense that he was essentially asking, "Can I count on you? Is your caring real, or do you see me as unworthy?"

There can sometimes be an amoral quality to psychoanalysis. An emotional distance. The patient acknowledges feelings of rage or hate and the analyst might look on with a blank stare and nod. There's often nothing relational or life-affirming. The therapeutic model can help improve impulse control, but it

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many patients on the ward, Lewis was given medications to suppress hallucination and delusion. Most patients on Unit 6 had been diagnosed with schizoaffective disorder—like Lewis—or with bipolar or major depressive disorder. But diagnosing patients was often like throwing darts at the wall—equal parts guesswork and chance. In the absence of a clear or effective treatment plan, the residents were routinely medicated to dull their pain and to suppress their volatile and sometimes violent behavior. The unit chief, a short, dark-haired Italian American man in his early fifties, known on the ward for his genuine caring and kind smile, had once told me, "The fact that we have medication is an act of grace." He was right. The drugs did muffle patients' discomfort and prevent outbursts. But the medication also made them foggy and lethargic, sometimes unable to control their own muscle movements. They would often drool, or their limbs would jerk in involuntary spasms. I was beginning to wonder if our role was more to mute the patients' symptoms than to heal their inner suffering.

As Lewis and I joined the other patients and staff in the community room for the daily meeting, there was no warmth in the room, even with the autumn sunshine spilling in through the large windows. Though the purpose of the meetings was to build community and engage in group therapy, everything felt impersonal. There was no coziness to the shabby furnishings or minimal decor. Plastic chairs were arranged in a huge oval, the plastic wood-veneer tables pushed to the edges of the room. The air smelled sharply of cleaning agent and cafeteria food.

Lewis and the other patients sat slumped with their arms crossed and bodies rigid, staring at their feet, speaking only if forced to. Even before the meeting had begun, they appeared anxious, beholden, powerless, and paranoid. The meetings often felt more like sentencing hearings, with patients terrified that saying the wrong thing would commit them to the ward for another week. I wasn't sure if the staff was deliberately using anxiety to fuel insight, but it didn't seem to be helping patients heal.

I took my place in the oval of chairs and greeted several patients near me: Rebecca Rabinowitz, a woman in her late

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thirties, with dark hair and blue eyes, had been experiencing severe depressive episodes for more than fifteen years, and had been admitted to the ward most recently for attempted suicide by overdose; Bill Manning, in his early forties, had been nearly incapacitated by bipolar disorder since he was in college; Jerry Petrofsky, one of my individual psychotherapy patients, in his early sixties, a city engineer known in the community for bicycling around the West Side, was admitted for attempting suicide during a bout of acute depression in reaction to a leukemia diagnosis.

I looked around the room for Esther Klein, a woman in her early seventies who had always reminded me of the women I knew from the synagogue my husband, Phil, and I sometimes attended. She appeared robust and healthy—but I knew from staff meetings that she was a Holocaust survivor. Her doctor believed that in order to heal, she needed to face her suffering. He'd pushed her during group and individual therapy to revisit her worst memories again and again. She had reluctantly spoken a few times at morning meetings about how she had escaped the death camps by living in hiding. Once, she told about a time she'd been forced to lick up vomit from the floor. Despite her doctor's best intentions, requiring her to describe her worst memories didn't seem to help her. Recently, I'd noticed her facial expressions were becoming flatter and more distanced, her arms wrapped more tightly around her body. She had grown noticeably more anxious and removed, as though the terrible past was sucking her backward. Today I didn't see her anywhere in the circle.

The psychiatrist running the meeting leaned forward in his chair and cleared his throat, signaling that the meeting had begun.

"I'd like to introduce our guest, Mr. Lawrence, from the hospital's administrative office." He gestured toward a visitor I'd never met, an authoritative-looking man in a dark suit.

"Yes, good morning," Mr. Lawrence said. "I have an unfortunate item to address." He held up a thick patient file. "I regret to inform the community of the passing of one of our longtime patients, Esther Klein."

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My stomach dropped.

A fellow intern leaned close and whispered in my ear, "She committed suicide last night. Can you believe it? Right before the High Holidays."

"Esther had a long and painful life," Mr. Lawrence continued. "I have read the patient's file. It's a sad story, but nothing could have been done."

Looking around the room at the dozens of patients, I suddenly saw them as victims of institutionalization rather than patients getting the care they needed: Lewis, whose earlier urgency had vanished behind a fog of medication, and who now stared vacantly at the wall. Rebecca, who spoke in apologetic tones, often expressing guilt and inadequacy. Bill, known on the ward for being highly volatile, attempting to bridge his alienation through bullying and disruptive behavior—angry outbursts, crude sexual overtures, wall pounding. Jerry, perpetually sullen, rarely rising from bed. They might leave the ward for a time, and then they would be back. What were we really offering them?

Mr. Lawrence closed the file on Esther's life, and the meeting continued, but everyone in the room seemed tense—faces flat, bodies rigid, hands gripping the plastic armrests of the chairs. Esther was dead—one of us, someone who had sat within our circle. The announcement had come from a stranger who had dealt with the crisis in a sterile, minimal way, with no time or space allowed to process what had happened or mourn the loss. We were gathered for the purpose of therapy, and yet the tone and process were the opposite of therapeutic. I knew that later the staff would hold a post-morbidity meeting, but the purpose was more to cover the hospital legally. We wouldn't be invited to respond to Ms. Klein's death in a personal way, or to reflect on our clinical techniques, on the fact that the only treatment she'd been offered had forced her to relive her trauma until the anguish had become unbearable. We were supposed to carry on as though a preventable death hadn't happened on our watch.

Just then my patient Jerry spoke into the silence. His face was red, his voice clipped. "What's being done for Yom Kippur?" he demanded.

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Many of the patients and doctors, myself included, were Jewish. Yom Kippur, the Day of Atonement, is the holiest day in Judaism, a time of forgiveness and renewal after Rosh Hashanah, the start of the Jewish New Year. Before you ask God for forgiveness, you ask forgiveness of those you have harmed, and then you're cleansed of your sins. Many of the staff would be away in observance of the holiday. But religion was spoken of so rarely on the ward that even though Jerry was my patient, I'd had no idea he was Jewish. And I hadn't considered the fact that no service would be available for the many Jewish patients.

The presiding psychiatrist said that nothing was planned.

Rebecca raised her eyes as though searching for someone, then dropped them. Bill beat his fists against his thighs.

"*Nothing* is planned?" Jerry fumed. *"Nothing?"*

THAT EVENING I waited for the subway—the living lab, as I called it. The platform was full of high school kids traveling in packs, yelling and joking; exhausted-looking elderly people carrying bags of groceries; a terribly thin man holding a sign: HIV POSITIVE, JUST OUT OF THE HOSPITAL, NEED MONEY FOR A MEAL, GOD BLESS. The air was muggy and smelled of old tires and damp basements. When the train screeched to a stop, I lurched on board, finding a spot between the moms and nannies jostling strollers into the car, pulling young kids onto their laps, and the well-groomed men in sumptuous suede and pinstripe jackets and silken ties reaching for newspapers as they found a place at the handrail, their expressions absorbed yet somehow vacant. I looked carefully at the faces all around me. Many people were visibly suffering. The woman with wild eyebrows and coarse gray hair dyed a brassy orange, dirty cheeks creased with wrinkles, ranting and muttering. The young woman with soft, milky dark skin who called quietly up the car, half-singing her plea: "Me and my baby daughter need a dollar to get to the shelter tonight." The man in a worn-looking full-length wool coat, his body still trembling with the effort it had required to sit down.

Other passengers showed no outward signs of distress. They appeared to have homes and money and good health, they carried briefcases or bags from department stores, tissue paper rustling out of the top. Their faces didn't cave in despair or

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trouble or strain. But they still had a walled-off look, their brows furrowed, their eyes cast deep into their newspapers or their laps. They looked so dissatisfied and burdened and checked-out. As if the weight of the world bore down on them, and something vital was missing.

The clinical term for this is "dysthymia"—the low-grade feeling that life is unfulfilling. It feels like emptiness. Hunger. Disillusionment. Life is not what you'd hoped. It's a less severe version of what I saw every day on the inpatient ward: alienation, isolation, futility, darkness.

And it's what I recognized in my husband and many of our friends. We were young, in our twenties, full of energy and professional drive, committed to living and working in a way that contributed to the world. But sometimes the rush and buzz of our day-to-day felt more like treadmill than calling. Phil especially hated the elevator ride to and from his corporate law office each day, the way people boarded, raised a hand in greeting, and then looked down at their feet. It was like living on the two-dimensional rendering of an office set. It looked adequate from far away, but up close the whole thing was fake—and terribly lonely. We talked incessantly with our friends about work promotions and apartment upgrades. Almost every sentence began, "If I can just make it through x, y, z ...," then I can advance, then I can rest, then I can be happy. Among successful friends who had the educations, opportunities, jobs, friends, and romantic partners they'd always wanted, it seemed from our conversations that there was still an emptiness. A near-constant craving. A sense that life was not as meaningful or joyful as it might have been. As though we were on a never-ending staircase toward fulfillment, happiness always just out of reach.

The suffering in the world seemed so pervasive and relentless. I resolved that at the very least I would try to do something to help Jerry and Bill and the other patients on Unit 6.

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or running for the elevator, I sometimes felt that we'd traded richness for hollowness, openness for narrowness. That in choosing to play it safe, we were cutting ourselves off from a fuller life. "I'll work another six months," Phil had recently told me. But in six months, would he really quit? Or would he decide to work another year so we could save for a baby or our next apartment that would be only slightly less tiny than the one we lived in?

I didn't yet have the science to explain it, but we were beginning to suffer from choices made through what I would later understand to be our achieving brains, chasing down sensible goals—of advancement, protection—that would not fulfill us, that would cultivate stress and fear and disconnection, because outward goals are no substitute for larger meaning and purpose. We were living half-awake, and I didn't yet know the importance of awakening—much less how to do it.

While Phil tidied up the kitchen after our meal, I dug around in the boxes where I stored my grad school psychology books. At last I found it: my grandmother's old prayer book. It had first belonged to her mother, my great-grandmother, who had brought it over on the boat from Russia. My grandmother had inscribed her name and address inside the front cover: *Harriet Aliber Friedman, 311 51st Street, Des Moines, Iowa.* Perhaps her fellow congregants at Temple B'nai Jeshurun sometimes went home with the wrong prayer book. Grandma made sure she held on to hers. It was the same book that my sweet, soulful mother had used when she studied for her bat mitzvah the year she turned fifty, somehow catalyzed by the second half of life to ever deepen her spirituality. The binding of the book was frayed, the pages soft from years of being turned. I held it carefully, half afraid it might fall apart in my hands.

A WEEK LATER, when I arrived for our Yom Kippur observance at the Unit 6 kitchen—a windowless, antiseptic room with a round plastic table sitting on a tired-looking beige-and-white linoleum floor—they were already there: four Jewish participants and their supportive attendants. Rebecca, Bill, and Jerry had come, and so had Sol Stein, a thirty-eight-year-old admitted to the ward for barricading himself in a midtown hotel

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room and then struggling with the police officers who eventually pulled him out. He had such a fear of others that social interactions could trigger psychosis. He managed his social phobia through extreme isolation; he rarely left his room on the unit.

They had arranged the chairs in a circle and were seated as if at their own kitchen table, inhabiting the depressing room with a sense of intimacy and warm solemnity. This was the first time I'd seen residents interacting this way. It was normal to see patients in the common room with their chairs pulled up to a wall, or the more volatile people picking fights. In contrast, Rebecca, Jerry, Bill, and Sol were visibly here to connect. They'd dressed up in slacks, sweaters, button-up shirts. Rebecca had put on dark pink lipstick.

Given how socially withdrawn the four were, especially Sol, I wasn't sure to what extent they would participate in the prayers. But when I began the service, all four immediately commenced chanting, building into a robust chorus. Jerry, though he'd never said a word to me about being Jewish, recited whole passages of Hebrew text from memory. Bill tapped his foot along to the prayers, and Rebecca, usually so remote and guarded, leaned forward, her posture open. We conversed about the service as we went, everyone collaborative and gracious, taking turns reading sections in English, interpreting the holiday prayers, sharing insights. The attendants, usually called on to restrain patients or enforce rules, also seemed absorbed in the fluid rhythm of the prayers; though they were unfamiliar with the service, their presence and sensitivity added reverence.

We made our way through the service as I recalled it from my childhood. I was no scholar or expert, so I relied on what my mother had explained was the purpose of Yom Kippur—to acknowledge our sins and request forgiveness, to express gratitude for our lives, to confirm our identity as Jews. The patients became dramatically enlivened as the service progressed, their eyes brightening as we read and sang. Rebecca sat up taller and sang fully, without her usual muted tone. Jerry read robustly. Sol started to officiate and correct us on the mechanics of the service. When we reached a rough patch with

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the Hebrew, he led us through the pronunciation. Bill, despite being filled with energy, did not erupt in a manic display. He rocked assuredly with his eyes closed as he sang. The attendants, though they weren't Jewish, sang too, all of us joined together in an unlikely universal congregation.

Near the end, we paused the formal service to each offer a word about our individual experience of Yom Kippur. Jerry offered, "How can you not believe in an all-powerful God of goodness when you look around and see the beauty of the universe!"

I was completely stunned to hear such a confident statement of faith from my patient who usually lay in bed, trapped in a state of despair and futility.

Rebecca was next. "Thank you for the service, I have nothing to say."

My turn came. "Yom Kippur for me is very important because I make mistakes," I said. "I mess up. This is a time when I ask the people in my life forgiveness and then ultimately ask God for forgiveness."

Sol turned to me. "God will forgive you," he said. "God always forgives everyone."

Again, I was stunned. Sol, who feared people to the point of barricading himself in a hotel room, was offering me counsel, extending himself to care for me.

When it was Bill's turn, he bashfully confessed, "I'd like to apologize to God for cheating on my diabetic diet ... but God knew all along." We all laughed.

The room felt cleansed and fresh, those of us around the table more connected to one another, and to something much bigger. But I had no reason to believe that the changed attitudes or atmosphere would carry back to normal life on the ward.

LATER THAT DAY I was in the interns' office, doing paperwork, when someone knocked on the door. Sol stood on the threshold, shoulders squared. He reached out his hand. "I want to thank you again for the service," he said. And then he emphasized what he had told me earlier: "God will forgive you. He always forgives."

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That evening, after I'd packed up for the day and was heading down the hall to leave, Rebecca rushed up behind me. "I had a realization during the service," she said. "I always knew that Yom Kippur meant you could do penance for your sins. I knew you could admit to being wrong. But the service showed me that I could be forgiven. I had never realized this before." In her long years of severe depression, Rebecca had relegated her entire existence to an apology. She seemed guilty to exist at all. But now she was communicating something completely antithetical to her core view of herself.

For Sol and Rebecca and the other patients, the service had loosened the hold of a prison.[1] It wasn't just that they appeared uplifted by the ceremony—it was that each person was more connected and restored in exactly the place where they were habitually cut off or occluded. The ceremony seemed, with laser precision, to have brought light into each person's darkest corner. Rebecca expressed feelings of self-worth; Sol exhibited deep connection and caring for others; Bill seemed steadier and more integrated; and Jerry articulated gratitude and appreciation for life. I had no idea why or how, no reason to trust that it would last. But something had happened in the back kitchen that wasn't happening through the primary medical interventions of medication and psychotherapy—and the healing, however temporary it might turn out to be, was specific to each patient's greatest need.

As a clinician—and as a scientist—I wanted to know: What had really happened at our Yom Kippur? Were patients uplifted by the familiar sense memories, by feeling at home culturally, practicing rituals they'd grown up with? Or was it the dignity of coming together, not as people with pathologies and treatment files but as fellow observers, that had brightened them, meeting in the back kitchen the way we might have met a different year at the neighborhood synagogue? Did the blast of illumination each patient had received offer anything of substance to practitioners working to support their longer-term healing?

Before leaving that day, I raised the question with my clinical supervisor. She listened thoughtfully. Finally, she said, "Lisa, it was very nice that you came in on your own religious holiday,

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and I can hear that the service was comforting to the patients. But the bottom line for them is a lifetime of medical illness. These patients are very sick. And that's our bottom line, too. This is a hospital."

Her implication was clear: spirituality was off-limits in our profession. I'd broken an unspoken rule—and I'd discredited myself by buying into a belief system that wasn't in keeping with medicine's rigor.

The conversation was over.

I WENT FOR a run that evening, heading north on Central Park West to the natural history museum, where I crossed into the park, following paths that wound through North and East Meadows, around the pond, through the woodsy Ramble, and down to Bethesda Fountain. I'd been a distance runner since high school when my father, a theater professor at Washington University in St. Louis, had received a major promotion, and our family moved east so he could accept his new post in the performing arts school at Boston University. Because I wanted to log as many miles as possible, I joined the boys' cross-country team, ran road races, and was an unofficial contestant in the Boston Marathon when I was fifteen, back when it was considered okay to spontaneously jump in and run the race. I'd been interviewed at the starting line in Hopkinton, apparently the youngest female at that time to have attempted the race. At the finish line down in Boston, two girls from my new high school, girls I'd met only a few times, embraced me like lifelong friends, eyes full of tears. Nobody in my family had envisioned that I would make it 26.2 miles to the finish, so they weren't there to greet me. A kind manager from a local Wendy's invited me in and offered me anything I wanted to eat to celebrate. The next week my mother took me to the doctor, worried about the effects of long-distance running on young girls, at that time so uncommon as to be uncharted. The doctor said I was fine, and I learned from the marathon that to finish a race you simply keep running; I learned to revel in the company of runners from around the world and the marvelous range of humanity standing in the streets to cheer everyone on, and to keep going until the finish line finds you.

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