DSM-IV Religious & Spiritual Problems

The inclusion in the *DSM-IV* of a new diagnostic category called "Religious or Spiritual Problem" marks a significant breakthrough. For the first time, there is acknowledgment of distressing religious and spiritual experiences as nonpathological problems. Spiritual emergencies are crises during which the process of growth and change becomes chaotic and overwhelming. The proposal for this new diagnostic category came from transpersonal clinicians concerned with the misdiagnosis and mistreatment of persons in the midst of spiritual crises. In addition, this course covers religious problems.

This online course covers the history of pathologizing theory regarding religion and spirituality in the mental health field, the work of Stanislav and Christina Grof, John Perry, John Mack, R.D. Laing, and many other clinical approaches for working with religious and spiritual problems including:

*** Mystical experience**	***New Religious Movements and cults**
*** Psychic opening**	*** Visionary experience**
*** Kundalini awakening**	*** Near-death experience**
*** Possession experience**	*** Shamanic crisis**
***Loss of faith**	*** Alien encounters**
***Terminal & life-threatening illness**	
***Changes in membership, practices & beliefs**	

20 examples in the **Case Library of Religious & Spiritual Problems**
200 web sites in the **WWW Library of Religion and Spirituality**

David Lukoff, Ph.D., is a Professor of Psychology at Saybrook Graduate School, and has been called a pioneer of online CE learning. He is the author of over 50 articles and chapters on religious and spiritual problems, and a co-author of the new diagnostic category "Religious or Spiritual Problem" in the *Diagnostic and Statistical Manual-IV*

Available for CE credits. Free to Visit Online Course

www.internetguides.com

Internet Guided Learning | 1035 "B" Street | Petaluma, CA 94952 | 888.880-2870

IGL 251: DSM-IV Religious and Spiritual Problems
Introduction

Why I created this Course • Course Description • Course Objectives • Instructions for Taking This Course • Approvals • Instructions for CE credit • Help with the Course • Software & Equipment needed • Cost & Refund Policy • Difficulties • Course Outline and Suggested Times

Why I created this course

My interest in spirituality and mental health dates back to 1971, when I spent 2 months in a spiritual crisis--convinced that I was a reincarnation of Buddha and Christ with a messianic mission to save the world. In my clinical practice as a psychologist and my work with the Spiritual Emergence Network for the past 25 years, I have often found myself face-to-face with individuals with the same beliefs. By giving me a rare opportunity to go through the complete cycle and phenomenology of a naturally-resolving psychotic episode, my spiritual emergency was a valuable clinical experience as well as a spiritual awakening! In 1994 my work in this area came to fruition when the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) included a category entitled Religious or Spiritual Problem (V62.89) of which I was a co-author. My personal objective in developing this course is to help people survive the perils of the spiritual path and reap the benefits of a consciously lived spiritual life.

Course Description

The inclusion in the DSM-IV of a new diagnostic category called "Religious or Spiritual Problem" marks a significant breakthrough. For the first time, there is acknowledgment of distressing religious and spiritual experiences as nonpathological problems. This course is designed to teach mental health professionals about the process of its acceptance, its definition, various types of religious and spiritual problems, differential diagnosis, and treatment of these problems. Online resources are used throughout so that participants are equipped to keep up with new findings and developments through the Internet.

Course Objectives

At the end of this course, you will be more culturally competent in treating religious and spiritual problems. Specifically, you will be able to:

1) discuss the background, history and rationale for the new diagnostic category, Religious or Spiritual Problem
2) describe the main types of religious and spiritual problems
3) differentiate religious and spiritual problems from psychopathology
4) choose more effective treatment modalities for religious and spiritual problems

Instructions for Taking This Course

The lessons for this course are online. For ease of later access, bookmark the Course Home Page, although you can always access it from the Internet Guided Learning homepage.

Each lesson opens into a new window, so when you are finished with a lesson, just close that window. The Course Homepage will still be there.

Or you can move to the next lesson by clicking on the Next Lesson link at the bottom of each lesson page, or the lesson links at the top of each lesson page.

Each link also opens into a new window, so when you are finished with visiting a site, close that window and you will return to the lesson. .

Most of the time you will be visiting sites on the World Wide Web, a part of the Internet. Thus you will need to have online access most of the time during the course. You can print the lessons out for even easier reading off-line, and then go back online to visit the links. None of the sites in this course charge for using their resources.

Four types of links are used in the course.

The links marked with the Eyeballs are required for CE credit. Some are Quiz items and some are Quest Search exercises which require finding a specific piece of information or type of resource. The Webquest is a popular method for teaching Internet skills in k-12 settings. I have adapted that approach because it is congruent with my commitment to a constructivist approach to education that fosters learning by doing. Note that only 75% of the Quiz and Quest Search exercises need to be completed correctly so if you have difficulty locating one of the resources, just go on to the next Quiz or Quest item.

The Globe, the Speaker, and the Book represent different types of resources that are also part of the course. Look them over although they do not involve quiz or quest exercises.

The links that are underlined in the body of the text are there as references if you want to check them out, such as the link to Webquest.

Approvals

Internet Guided Learning has approvals from:

California Board of Behavioral Sciences

California Board of Registered Nursing

American Psychological Association (Internet Guided Learning is approved by the American Psychological Association to offer continuing education for psychologists. Internet Guided Learning maintains responsibility for the program.) CE availability MCEP credit for psychologists in California is available by submitting the APA completion certificate.

Instructions for CE credit

Collecting CE requires filling out the CE Quiz Form and paying the tuition fee of $89. You can register and fill out the Online CE Quiz Form (includes a secure form for credit card payment). Most people prefer to print out this form and fill it in as they work their way through the course. Then complete the form online or mail or fax it to Internet Guided Learning (instructions are on the form). Include the tuition fee of $89 by check or credit card number. Your certificate awarding 8 hours of CE will be e-mailed to you.

Help with the Course
You can contact the instructor, Dr. David Lukoff, via email or by toll-free phone at 888.880.2870.

Software and Equipment Needed
You only need to have access to a computer with Internet service and a browser such as Netscape Navigator or Internet Explorer (which you probably have to be reading this!) Public libraries usually offer free access to the Internet.

Cost & Refund Policy
This course is free to preview. If prepayment is made, then a full refund is available at any point for any reason up until CE is awarded. Full refund is also available if your state board does not accept the type of CE that Internet Guided Learning awards. Contact the instructor, Dr. David Lukoff, via email (iguides@atbi.com) or by phone at 888.880.2870 to request a re fund.

Difficulties
Can't get to a link
The server for that site may temporarily be experiencing problems. If a link doesn't work, skip it and come back to it later. The site will probably be back up. Occasionally a site used in this course may have been taken down. Availability of links is checked regularly. If you have persisting trouble accessing a site, please notify the instructor.

It takes a long time for web site to appear
The World Wide Web has also been called the World Wide Wait. If you are using a slow speed modem (28k or less), or an older computer with a slow processor, web pages can take one or more minutes to appear. I have the late model Apple G4 Macintosh with a cable modem, and this combination brings up most web pages in a few seconds. But cable modems and DSL high speed lines typically cost $40-50 per month, more than twice what most Internet Service Providers charge. Many universities and libraries provide high speed access. Web pages do come up sooner when they are revisited because parts of the page are saved in a "cache" on your hard disk.

Course Outline and Suggested Times
There is some flexibility as to how to spend your time. The expectation is that you will spend 8 hours total on this course.

Introduction to Course-15 minutes
I Background of DSM-IV Category-60 minutes
II Religious Problems-60 minutes
Lesson 2.1 Religious Problems
Lesson 2.2 Loss or questioning of faith
Lesson 2.3 Changes in membership, practices and beliefs
Lesson 2.4 New Religious Movements and Cults
Lesson 2.5 Terminal and life-threatening illness
III Spiritual Problems-90 minutes

Lesson 3.1 Spiritual Emergence
Lesson 3.2 Spiritual Problems
Lesson 3.3 Mystical experiences
Lesson 3.4 Near-death experiences
Lesson 3.5 Meditation & Spiritual Practice
Lesson 3.6 Psychic experiences
Lesson 3.7 Visionary Experiences
Lesson 3.8 Shamanic experiences
Lesson 3.9 Alien Encounter Experiences
Lesson 3.10 Possession experiences
IV Co-Ocurrence with Mental Disorders-60 minutes
V Differential Diagnosis-60 minutes
VI Therapeutic Interventions-60 minutes
Lesson 6.1 Spiritual Crises
Lesson 6.2 Psychotherapy
VII Online Resources-60 minutes
Lesson 7.1 Online Resources
Lesson 7.2 Searching Medline
Filling out Continuing Education Quiz and Quest Search Exercises, and Evaluation Forms
15 minutes

IGL 251: DSM-IV Religious and Spiritual Problems Lesson 1 Background of Religious or Spiritual Problem (V62.89)

Mental Health and Spirituality • History of the DSM-IV Proposal • Nursing and Psychology

Mental Health and Spirituality

The mental health field has a heritage of 100 years of ignoring and pathologizing spiritual experiences and religion. Freud promoted this view in several of his works, such as in Future of an Illusion wherein he pathologized religion as:

> A system of wishful illusions together with a disavowal of reality, such as we find nowhere else...but in a state of blissful hallucinatory confusion.

Freud also promoted this view in *Civilization and Its Discontents,* where he reduced the "oceanic experience" of mystics to "infantile helplessness" and a "regression to primary narcissism." The 1976 report *Mysticism: Spiritual Quest or Psychic Disturbance* [1] by the Group for the Advancement of Psychiatry (GAP) followed Freud's lead in defining religion as a regression, an escape, a projection upon the world of a primitive infantile state.

Albert Ellis,PhD is the creator of Rational Emotive Therapy, the forerunner of cognitive modification approaches now widely used in cognitive-behavioral therapies. In a recent (2001) interview, Ellis stated:

> Spirit and soul is horseshit of the worst sort. Obviously there are no fairies, no Santa Clauses, no spirits. What there is, is human goals and purposes...But a lot of transcendentalists are utter screwballs.

In addition to his bias against spirituality as a constructive element in health, in many other of his writings he has also derided religion:

> The elegant therapeutic solution to emotional problems is quite unreligious ...The less religious they [patients] are, the more emotionally healthy they will tend to be" [2]

BF Skinner,PhD, the psychologist who pioneered understanding of behavior modification principles that are the other half of cognitive-behavioral therapies, did not publish a single word on the topic of spirituality. He approached humans as stimulus response boxes with varying behaviors that depend on environmental contingencies. Skinner's psychology gave no attention to inner experience, which does leave out a lot of what makes people human beings. However, Skinner's implicit views on religion can be

gleaned from the novel he wrote about a Utopian community, *Walden Two*. In this novel, one member describes religion as:

> an explanatory fiction, of a miracle-working mind...superstitious behavior perpetuated by an intermittent reinforcement schedule

These founders' views on religion and spirituality have had a profound influence on the clinical approach to these issue. M. Scott Peck, MD, author of *The Road Less Traveled,* highlighted the disastrous clinical consequences for all the mental health professions:

> Traditional neglect of the issue of spiritually has led to five broad areas of failure:
> occasional devastating misdiagnosis;
> not in frequent mistreatment;
> an increasingly poor reputation;
> inadequate research and theory; and
> a limitation of psychiatrists' own personal development.
> As a result, research on both psychopathology and mental health has largely ignored religion.

Larson et al. Systematic analysis of research on religious variables in four major psychiatric journals, 1978-1982

Surveys conducted in the United States consistently show a "religiosity gap" between the general public and patients who in many surveys report themselves to be more highly religious and to attend church more frequently than mental health professionals. And studies of training for psychologists and other mental health professionals show that despite the importance of religion and spirituality in most patients' lives, adequate training is not provided by most graduate programs and internship sites to prepare them to deal with these issues. (For a review see Lukoff D, Lu F, Turner R. Toward a more culturally sensitive DSM-IV: Psychoreligious and psychospiritual problems). The pathologizing and ignoring of religion and spirituality has also resulted in clinical insensitivity towards individuals who present with religious and spiritual problems and issues.

These negative views of religion and spirituality are not warranted in light of recent studies showing no association between religiosity and psychopathology in the nonpatient population. Controlled studies have also found that "The notion that religion exerts a negative influence on mental health in patients was not generally supported by our findings" (Pfeifer and Waelty, 1995). In fact, a meta-analysis of religiosity and mental health found them to be positively related. Church-affiliated individuals showed greater happiness and satisfaction with marriage, work and life in general. Studies of the self-reported relationship between quality of relationships with divine others (e.g., Christ, God, Mary, etc.) and several measures of well-being also found a significant positive association. While there does seem to be a relationship between religiosity and

psychopathology in the seriously mentally ill, for the vast majority of the population, spirituality and religion are associated with positive characteristics of mental health. Similarly, mystical experiences and spiritual practices are positively associated with mental health variables.

REQUIRED QUIZ ITEM 1
In " Psychopathology and religious commitment--a controlled study" Pfeifer and Waelty found that life satisfaction was significantly positively correlated with religious commitment.
True
False
Record your answer for later insertion into the Quiz.

See International Center for the Integration of Health and Spirituality (ICIHS) for summaries of over 1600 studies on these issues or Dr. David B. Larson's slide presentation on the link between health and spirituality (must have Powerpoint to view the slideshow).

REQUIRED QUIZ ITEM 2
_____ viewed religious beliefs as fantasies that prevent people from coming to terms with how things really are.
a) C G Jung
b) Sigmund Freud
c) Albert Ellis
d) b and c
Record your answer for later insertion into the Quiz.

History of the DSM-IV Proposal
To redress the lack of sensitivity to religious and spiritual problems, the course author along with two psychiatrists (Francis Lu, MD and Robert Turner, MD) on the faculty at UCSF Department of psychiatry proposed a new diagnostic category to the Task Force preparing the 4th edition of the DSM which was due to be published in 1994. We viewed such an addition to the nomenclature as the most effective way to increase the sensitivity of mental health professionals to spiritual issues in therapy. The initial impetus for this proposal came from the Spiritual Emergence Network (then called the Spiritual Emergency Network, now the Center for Psychological & Spiritual Health (CPSH)) which was concerned with the mental health system's pathologizing approach to intense spiritual crises.
(Detailed History of Proposal)

In December 1991, the proposal for Psychoreligious or Psychospiritual Problem was formally submitted to the Task Force on DSM-IV. The proposal stressed the need for this new diagnosis to improve the cultural sensitivity of the DSM-IV and also argued that the adoption of this new category would result in the following benefits:

increasing the accuracy of diagnostic assessments when religious and spiritual issues are involved
reducing the occurrence of iatrogenic harm from misdiagnosis of religious and spiritual problems
improving treatment of such problems by stimulating clinical research
improving treatment of such problems by encouraging training centers to address religious and spiritual issues in their programs

Support for the proposal was obtained from the American Psychiatric Association Committee on Religion and Psychiatry and the NIMH Workgroup on Culture and Diagnosis. The proposal in its entirety documenting the need for such a category was published in the Journal of Nervous and Mental Disease (Lukoff, Lu & Turner, 1992) . In January 1993, the Task Force accepted the proposal but changed the title to "Religious or Spiritual Problem" and shortened and modified the definition to read:

> V62.89: This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values which may not necessarily be related to an organized church or religious institution. (American Psychiatric Association, 1994, p. 685)

Articles on this new category appeared in *The New York Times, San Francisco Chronicle,* American Psychiaric Association *Psychiatric News*, and the American Psychological Association *Monitor,* where it was described as indicating an important shift in the mental health profession's stance toward religion and spirituality.

REQUIRED QUIZ ITEM 3
Religious or Spiritual Problem is
a) a type of neurosis b) a type of psychosis c) a proposed new diagnostic category for the DSM-V d) a new diagnostic category in the DSM-IV
Record your answer for later insertion into the Quiz.

Nursing and Psychology

Historically the nursing profession has been more receptive to religion and spirituality. Spiritual Distress has been a category in the nomenclature of the National Group for the Classification of Nursing Diagnosis since 1983 [3]. It is defined as "The state in which the individual experiences or is at risk of experiencing a disturbance in his or her belief or value system that is his/her source of strength and hope." Examples include:

Guilt
Inability to practice religious rituals
Conflicts between religious/spiritual beliefs and the prescribed health regimen
Lack of meaning in life
A disruption in the relationship with one's God
Lack of forgiveness toward a significant other

The mental health nursing journals also include religious and spiritual factors more frequently than psychiatry or psychology journals.
Weaver AJ, Flannelly LT, Flannelly KJ, Koenig HG, Larson DB. An analysis of research on religious and spiritual variables in three major mental health nursing journals, 1991-1995. Issues Ment Health Nurs 1998 May-Jun;19(3):263-76

The authors attribute this greater sensitivity to historical factors: Whereas the founder of modern nursing, Florence Nightingale, taught that spirituality was intrinsic to human experience and compatible with scientific inquiry, the founder of modern psychiatry, Sigmund Freud, had a strongly held view of religion as pathological.
According to the American Psychological Association *Ethical Principles of Psychologists and Code of Conduct,* psychologists have an ethical responsibility to be aware of social and cultural differences that impact treatment. Section 1.08 Human Difference states,

> Where differences of age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status significantly affect psychologists' work concerning particular individuals or groups, psychologists obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals.

Ignorance, countertransference, and lack of skill can impede the untrained psychologist's ethical provision of therapeutic services to clients who present with religious or spiritual problems. Differential diagnosis require knowledge of the patient's religious subgroup and/or the nature of acceptable expressions of subculturally validated forms of religious expression. Allen Bergin (1980)[4] wrote in the *American Psychologist,*

> Psychologists' understanding and support of cultural diversity has been exemplary with respect to race, gender, and ethnicity but the profession's tolerance and empathy has not adequately reached the religious client. (p. 95)

In contrast to psychiatric residency training where the Accreditation Council for Graduate Medical Education in 1995 issued "Special Requirements for Residency Training in Psychiatry" that mandates instruction about gender, ethnicity, sexual orientation, and religious/spiritual beliefs, such training is not specifically required in psychology.
Yet the mental health field is growing more sensitive to religion and spirituality as important factors in health and well-being. I concur with the assessment of Michael Washburn,PhD

> There still is a pathologization of anything that has to do with difficult religious experience. We are overcoming that, I am pleased to say. There is a growing appreciation that a passage into spiritual life can be psychologically very challenging, and that we should expect it as a common occurrence, and learn better to understand it so we can deal with it when it happens. I think we are in a

better situation as far as those possibilities are concerned than we have been in the past. But there's still some way to go.

References

1 Group for the Advancement of Psychiatry. (1976). Mysticism: Spiritual quest or mental disorder. New York: Group for the Advancement of Psychiatry.
2 Ellis, A. (1980). "Psychotherapy and atheistic values: A response to A, E. Bergin's "Psychotherapy and Religious Issues"." Journal of Consulting and Clinical Psychology 48: 635-639. (p. 637)
3 Carpenito, L. (1983). Nursing diagnosis: Application to clinical practice. Philadelphia, J. B. Lippincott.
4 Bergin, A. (1980) Psychotherapy and Religious Values. American Psychologist, 48, 1980, 95-105. (p. 95)

IGL 251: DSM-IV Religious and Spiritual Problems
Lesson 2.1 Typology of Religious Problems

COURSE LINKS

Typology of Religious Problems

The original proposal submitted to the Task Force on DSM-IV and published in the Journal of Nervous and Mental Disease included four types of religious problems that were identified through literature searches and surveys:

loss or questioning of faith
change in denominational membership
conversion to a new faith
intensification of adherence to religious practices and orthodoxy

In the final defintion of Religious or Spiritual Problem published in the DSM-IV, only two of the four types were included:

loss or questioning of faith
conversion to a new faith

V62.89: This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values which may not necessarily be related to an organized church or religious institution. (American Psychiatric Association, 1994, p. 685)

In this course, the typology of Religious and Spiritual Problems has been updated to reflect new findings. Included in Lesson 2 are four types of religious problems:

Loss or questioning of faith
Changes in membership, practices and beliefs (including conversion)
New Religious Movements and cults
Life-threatening and terminal illness

DSM-IV Religious and Spiritual Problems
Lesson 2.2 Loss or questioning of faith

Description • Associated Clinical problems • Treatment • Case Examples • WWW Library

Description
Loss of faith is specifically mentioned in the DSM-IV definition as a religious problem. There are several forms that loss of faith can take. Shafranske [1] described a man of professional accomplishment whose life was founded upon the conservative bedrock of Roman Catholic Christianity. He came to doubt the tenets of his religion and, in so doing, declared he had lost the vitality to live.

Some crises of faith are recognized as part of spiritual development James Fowler,hD, building on the work of Piaget, Kohlberg, and other developmental theorists, has proposed that there is an invariant order of faith development in six recognizable stages. Problems may arise in the transition from one stage to another, often experienced as a crisis of faith. (James Fowler, Stages of Faith).

A similar problem can occur when a person is ostracized by their religious community. One such crisis was created when a Jehovah's Witness elected to have a medically necessary heart transplant despite his family's and religious community's objections on religious grounds:

> His family and church community subsequently refused any contact with him. Ultimately, the patient became suicidal and required psychiatric hospitalization. (p. 476)
> Waldfogel S, Wolpe PR. Using awareness of religious factors to enhance interventions in consultation-liaison psychiatry. Hosp Community Psychiatry. 1993 May;44(5):473-7.

Associated Clinical Problems
For some individuals, loss of faith involves questioning their whole way of life, purpose for living, and source of meaning.. In addition, their social world can be affected since religion is for many an important part of their social network. Barra, Carlson and Maize [2] conducted a survey study and also reviewed the anthropological, historical, and contemporary perspectives on loss as a grief-engendering phenomenon. They found that loss of religious connectedness,

> whether in relation to traditional religious affiliation or to a more personal search for spiritual identity, frequently resulted in individuals experiencing many of the feelings associated with more "normal" loss situations. Thus, feelings of anger and resentment, emptiness and despair, sadness and isolation, and even relief could be seen in individuals struggling with the loss of previously comforting religious tenets and community identification. (p. 292)

In summary, these are the clinical sequalae that can result from a sudden loss of faith.

anger
resentment
emptiness
despair
sadness
isolation

Since this type of loss is typically not acknowledged by others, the authors described this phenomenon as "disenfranchised grief." They cite one case of a graduate student who stopped believing in her religion of origin. She reported feeling alienated, fear, anxiety, anger, hopelessness, and even suicidal ideation, the common sequallae of a grief reaction. The American Psychiatric Association's "Guidelines Regarding Possible Conflict Between Psychiatrists' Religious Commitments and Psychiatric Practice" mentions a case where a psychiatrist provided interpretations to a devoutly religious man. "In doing this, however, she denigrated his long-standing religious commitments as foolishly neurotic. Because of the intensity of the therapeutic relationship, the interpretations caused great distress and appeared related to a subsequent suicide attempt" [3] This is an iatrogenic effect of culturally insensitive treatment.

Studies have found that struggling with religious beliefs during an illness diminishes the chances of recovering. Persons whose faith is shaken when they fall ill are at greater risk of dying, thus documenting the consequences of a loss of faith. Kenneth Pargament,PhD of Duke University and colleagues studied 596 patients from 1996 to 1997 Participants were 596 patients aged 55 years or older on the medical inpatient services of Duke University Medical Center or the Durham Veterans Affairs Medical Center, Durham, NC. Patients who reported that they felt alienated from or unloved by God and attributed their illness to the devil or said they felt abandoned by their church community had a 19 percent to 28 percent increase in the risk of dying within the next two years, compared with those who had no such religious doubts, even after controlling for the patients' health, mental health and demographic status. Those who indicated that they "Wondered whether God had abandoned me" and "Questioned God's love for me" had a higher mortality rate. Dr. Pargemant indicated that these results highlight the need for spiritual assessment and pastoral interventions for patients whose faith is shaken by illness. Pargament KI, Koenig HG, Tarakeshwar N, Hahn J. Religious struggle as a predictor of mortality among medically ill elderly patients: a 2-year longitudinal study. Arch Intern Med. 2001 Aug 13-27;161(15):1881-5.

REQUIRED QUIZ ITEM 4
Pargament Study

83 year old Beth has been diagnosed with breast cancer, and has expressed the belief that the illness is a punishment from God for her sins. Based on the study Religious struggle as a predictor of mortality among medically ill elderly patients: a 2-year longitudinal study, she could be at increased risk of death.

True False Record your answer for later insertion into the Quiz.

Treatment
Michael Washburn, PhD has noted a possible focus for therapy by focusing on the change as a turning point in faith which offers the potential for personal exploration and discovery:

> If, later in life, we suffer a profound disillusionment in our experience of the world, we may find ourselves turning back towards psychic resources that previously we had repressed. This is the beginning of what I have called "regression in the service of transcendence", which I think most people would know better using the term of St. John of the Cross, "the dark night of the soul". It can be a very long, difficult, and trying period.

For people who find themselves in this passage -- as I did 20 years ago -- it is helpful to know that it is a passage. It's helpful to know that perseverance and patience are important, and that it is a time to grow in faith. Frequently it may not look like faith, because the old idols have disappeared, and the old god-ideas have fallen by the wayside. It therefore can look like a loss of faith, and a loss in one's life-direction generally. But this can really be a turning point in faith, the beginning of a mystery, a movement towards an "I know not what" that, though distressing, can also be the real stuff of spiritual experience and of a spiritual relationship.

The therapist can view loss of faith as an opportunity for the patient to grow into a new relationship to the mystery of life. For some who are experiencing loss of faith, work with a religious professional might help them to reconnect with their faith.
Others may not want to get involved with an organized religion. The creation of a new personal mythology as described in Lesson 6.2 is a psychotherapeutic priority in working with clients who have experienced a loss of faith.

Case Examples
S. is a 58-year-old European-American single client who has had progressive liver disease for 2 years. Before her illness, she attended church regularly and volunteered her free time to church-related charity organizations. When given the diagnosis, she ceased her involvement with the charities and attending church services because she says she "has no need to worship a fantasy." During her fourth hospitalization, she was informed that the disease process was not responding to treatment and that her death could occur in the next few weeks. Upon discharge, she became clinically depressed, refused to take any medications, ceased eating, spent her time gazing out of her room or reading books, and complaining that "God had abandoned her." A relative notified a mental health professional. At the intake, she ignored most questions and complained that life seemed so meaningless.

Emma Bragdon has described a similar crisis of faith around her spiritual path of Buddhism.

WWW Library of Religion and Spirituality
The WWW Library contains a directory of sites on losses of all kinds and articles by James Fowler and Michael Washburn.

References
1 Shafranske, E. (1991). Beyond countertransference: On being struck by faith, doubt and emptiness. American Psycholgical Association, New Orleans, LA.
2 Barra, D., Carlson, E., & Maize, M. (1993). The dark night of the spirit: Grief following a loss in religious identity. In K. Doka & J. Morgan (Eds.), Death and spirituality. Amityville, NY: Baywood.
3 APA Committee on Religion and Psychiatry (1990). "Guidelines regarding possible conflict between psychiatrists' religious commitments and psychiatric practice." American Journal of Psychiatry 147: 542.

DSM-IV Religious and Spiritual Problems
LESSON 2.3 Changes in membership, practices & beliefs

Description • Associated Clinical problems • Treatment • Case Examples • WWW Library

Description

Changes in Membership
Due to intermarriage, mobility and the breakdown of geographic limitations to church membership, many people convert to new religions or change their denominational membership. In some cases the change may be experienced as forced rather than voluntary. When a person moves to a community which does not have a branch of the original religious group, he or she may experience a sense of loss associated with separation from a previously valued religious community. Conversion experiences in particular can lead to adoption of a new religion or change in denominational membership.

Intensification of Belief
Another type of religious problem can occur when a person intensifies their adherence to religious practices and orthodoxy. Voluntary intensification of religious practice may be the result of a religious experience. This can lead to problems when the person either does not feel free, or does not know how, to talk about the religious aspects of the change. But such intensification may also occur as an attempt to deal with feelings of guilt. Intensification may also be one of the coping mechanisms used to deal with trauma, and is associated with the need to find meaning in the distressing event in order to avoid a breakdown of identity [1].

Conversion Experiences
According to William James, a conversion experience involves

- sense of a higher control or power behind reality
- feeling of oneness with the world and nature
- sensing profound "truths" about reality
- everything looking new, alive, and beautiful
- being overwhelmed with happiness and ecstasy
- inability to express this experience in words
- absolute certainty about the importance of this experience

Cultural and social factors play an important role in the conversion process, and different religions and disciplines view conversion differently, from welcoming to questioning such direct experiences.

Associated Clinical Problems
Changes in beliefs and practices

> quite often do in fact disrupt peoples' lives. It does disrupt families. Even though we may give a theology of conversion that can soft pedal all those issues, the truth is, the issue is controversial because it is disruptive...a disorientation, and something that has caused a lot of complications in many peoples' lives.
> T*he Psychology of Religious Conversion*, Lewis Rambo

Intensification of religious practice can also be misdiagnosed as mental disorders. Greenberg and Witzum[2] are Israeli psychiatrists who work with orthodox Jewish patients. They have proposed diagnostic criteria for distinguishing normative strict orthodox religious beliefs from psychopathological experiences that present with religious content.
Symptoms of Mental Disorder:

1) are more intense than normative religious experiences in their religious community
2) are often terrifying
3) are often preoccupying
4) are associated with deterioration of social skills and personal hygiene
5) often involve special messages from religious figures

At times devout religious practices can be viewed as extreme and result in conflict with the law as with mutilation, a practice associated with several religions.
Abu-Sahlieh SA, To mutilate in the name of Jehovah or Allah: Legitimization of male and female circumcision. Med Law 1994;13(7-8):575-622

Treatment
If the patient is newly religious, the therapist needs to help identify and work on conflicts between the patient's former and current lifestyle, beliefs, and attitudes. Spero (1987)[3] described the case of a 16-year-old adolescent from a reform Jewish family who underwent a sudden religious transformation to orthodoxy. The dramatic changes in her life, including long hours studying Jewish texts, avoidance of friends, and sulleness at meals, led to her referral to a psychoanalyst. A mental status examination determined that neither schizophrenia nor any other Axis I or II disorders were present. The analysis then dealt with the impact of religious transformation on her identity and object relations. The process of religious change challenges important areas of stability, and
to some degree the sense of historical dislocation represents a crisis for all nouveau-religionists. (p 69)

As in the case example below, religious experiences can impact treatment, both of medical and mental problems.

Case Examples
Case Report: Decision-Making Capacity and Religious Conversion-- A Case of Dialysis Refusal

Dinesh Mittal, MD, Samuel F. Sears Jr., PhD, Phillip R. Godding, PhD, and Marti D. Reynolds, MDiv (1999) Annals of Long-Term Care, 7(8),320-322

REQUIRED QUIZ ITEM 5
Dialysis refusal
In Case Report: Decision-Making Capacity and Religious Conversion-- A Case of Dialysis Refusal, the authors describe their approach to working with dialysis refusal by: a) getting a legal mandate to enforce treatment b) working within the patient's belief system c) using rational disputation techniques d) none of the above
Record your answer for later insertion into the Quiz.

Woman's first person account of conversion to Catholicism

WWW LIBRARY of Religion and Spirituality
The WWW LIBRARY of Religion and Spirituality contains articles on the psychology of religious conversion.

REQUIRED QUIZ ITEM: 6
Types of Changes

Religious problems can be related to a) changes in membership b) intensification of beliefs c) conversion d) all of the above
Record your answer for later insertion into the Quiz.

References

1 Van der Lons, J. (1991). What is psychology of religion about? Psychology of religion. H. Malony. Grand Rapids, MI, Baker.
2 Greenberg, D., & Witztum, E. (1991). Problems in the treatment of religious patients. American Journal of Psychotherapy, 45(4), 554-565.
3 Spero, MH (1987). Identity and individuality in the nouveau-religiouis patient: Theoretical and clinical aspects. Psychiatry. 50, 55-71.

DSM-IV Religious and Spiritual Problems
LESSON 2.4 New Religious Movements and Cults

Description • Associated Clinical problems • Treatment • Case Examples • WWW Library

Description

Participation in cults has been claimed to:

break up families
brainwash people to gain and hold them as members
cause irreparable psychological damage

Cult Experience: Psychological Abuse, Distress, Personality Characteristics, and Changes in Personal Relationships Cultic Studies Journal, Vol. 15, No. 2, 1998

But membership in cults isn't uniformly oppressive and detrimental to mental health. A comprehensive review of the recent literature found good evidence that some of them are helpful to their adherents [1] Vaughan [(2]also points out that many individuals who joined and then left destructive groups reported that the experience contributed to their wisdom and maturity through the process of empowering a sense of having met the challenge by restoring their integrity. For the vast majority, such "radical religious departures" are part of adolescent or young adult identity exploration. Also since over 90% of persons who join new religious groups leave within two years, Stephen Post,MD points out that "if brainwashing goes on, it is extremely ineffective" (p. 373).
Stephen Post,MD, Psychiatry Psychiatry and ethics: the problematics of respect for religious meanings.Cult Med Psychiatry 1993 Sep;17(3):363-83

Dr. Post also points out the need to distinguish socially controversial new religious movements (NRMs) from cults, even though distressed families have pressured mental health professionals to assess the mental state of recruits to such sects. While carrying a negative connotation in the mental health field, cult also carries the non pejorative meaning of a grouping of people for some religious purpose. All religions originally began as cults, and however mainstream they have eventually become, the major world religions were originally perceived as a threat to established customs and values.
It is also important to remember that the Peoples Temple church which was responsible for the mass suicide at Jonestown in Guyana was a mainline congregation of a group called Disciples of Christ. At the time it had about one million members. They were members of the National Council of Churches. One of its lay leaders was a prominent person in the California Council of Churches. This group became identified as a cult only after the death of the members who were in Guyana. New Religious Movement is the term that sociologists often use to refer to small religious groups that are not destructive.

Nevertheless, some genuinely dangerous and destructive groups do arise under the banner of religion. A recent example is the Branch Davidians.
Essay on Definition of Cult by Michael Langone,PhD
The Cult Threat: Real or Imagined Gordon Melton

REQUIRED QUIZ ITEM 7
New Religious Movements (NRMs)

According to The Cult Threat: Real or Imagined, membership in New Religious Movements is mainly in odd retreat centers and country communes.
True
False
Record your answer for later insertion into the Quiz.

Associated Clinical Problems
Nine factors have been associated with recruitment into cults:

a) generalized ego-weakness and emotional vulnerability
b) propensities toward dissociative states
c) tenuous, deteriorated, or nonexistent family relations and support systems
d) inadequate means of dealing with exigencies of survival
e) history of severe child abuse or neglect
f) exposure to idiosyncratic or eccentric family patterns
g) proclivities toward or abuse of controlled substances
h) unmanageable and debilitating situational stress and crises
i) intolerable socioeconomic conditions.
Factors related to susceptibility and recruitment by cults by Curtis JM, Curtis MJ. Psychol Rep 1993 Oct;73(2):451-60

It can be difficult for mental health professionals to determine what is a cult. In popular jargon "cult" carries the implication that the group uses intimidation, coercion, and indoctrination to systematically recruit, initiate, and influence inductees.
Distinguishing between religious nonconformity and mental disorders is an issue of cultural competence. The first clinical concern is assessing whether the group shows the signs of spiritual group pathology that distinguish a misguided cult from wholesome spiritual communities. Wellwood [3]lists these characteristics of pathological communities: :
The leader has total power to validate or negate the self-worth of the devotees, and uses this power extensively
The group is held together by allegiance to a cause, a mission, and ideology
The leader keeps his followers in line by manipulating emotions of hope and fear
"Groupthink" is used to knit followers together
Cult leaders are usually self-styled prophets who have not studied with great teachers or undergone lengthy training or discipline

Treatment

In 1989, the American Psychiatric Association's Committee on Psychiatry and Religion called upon psychiatrists to help temper the anti-cult fanaticism that often afflicts a distressed family. Yet mental health professionals have been under pressure since the early 1980's, after the Jonestown massacre, to sanction the forcible deprogramming and involuntary hospitalization of religious seekers who were 'turning East'.
Post SG Psychiatry and ethics: the problematics of respect for religious meanings. Cult Med Psychiatry 1993 Sep;17(3):363-83
"Exit counseling," which is less coercive, has largely replaced "deprogramming." Deprogramming, Exit Counseling, and Ethics: Clarifying the Confusion by Michael D. Langone, PhD and Paul Martin, PhD

Vaughan [2] has described a psychotherapeutic approach that examines the psychological consequences of joining a group that purportedly offers spiritual self-realization. This client centered approach does not evaluate the relative merit of alternative spiritual practices or try to determine whether the "teacher" is a true spiritual authority. She points out that individuals may have any of a number of motivations for joining a group, ranging from difficulty supporting themselves, to loneliness, to actualizing their potential by progressing along a path of spiritual development. In therapy with someone who has left, or who is considering joining or leaving a NRM or cult, the client could be asked to consider the following questions:

> What attracts me to this person?
> Am I attracted to his or her power, showmanship, cleverness, achievements, glamour, ideas?
> Am I motivated by fear or love?
> Is my response primarily physical excitement, emotional activation, intellectual stimulation, or intuitive resonance?
> What would persuade me to trust him/her more than myself?
> Am I looking for a parent figure to relieve me of the responsibility for my life?
> Am I looking for a group where I feel I can belong and be taken care of in return for doing what I am told?
> What am I giving up?
> Am I moving towards something I am drawn to, or am I running away from my life as it is.

Often students transitioning from the "culture of embeddedness" with their teachers into more independent functioning seek psychotherapeutic help. Bogart [4] has reviewed the various disturbances and problems that can occur in the relationship between a student and his/her spiritual teacher. (See case example below.)

Case Examples
Separating from a Guru-Greg Bogart,PhD
Anemia and limping in a vegetarian adolescent by Chiron R et al. Arch Pediatr 2001 Jan;8(1):62-5

REQUIRED QUIZ ITEM 8 Cult and Diet

In Anemia and limping in a vegetarian adolescent , the adolescent on the vegan diet imposed by the cult was deficient in a) calcium b) vitamin D c) vitamin B12 d) all of the above
Record your answer for later insertion into the Quiz.

WWW LIBRARY of Religion and Spirituality
The WWW LIBRARY of Religion and Spirituality contains articles on cults and NRMs.
References
1 Rochford,E, Purvis,S Eastman (1989). New religions, mental health, and social control. In Lynn, Monty L. (Ed); Moberg, David O. (Ed). Research in the social scientific study of religion: A research annual, Vol. 1. (pp. 57-82.
2 Vaughan, F. (1987). A question of balance: Health and pathology in new religious movements. In Spiritual choices: The problem of recognizing authentic paths to inner transformation. D. Anthony, B. Ecker and K. Wilber. New York, Paragon House: 265-282.
3 Welwood J (1987) On Spiritual authority: Genuine and counterfeit In Spiritual choices: The problem of recognizing authentic paths to inner transformation. D. Anthony, B. Ecker and K. Wilber. New York, Paragon House: 283-304.
4 Bogart, G. C. (1992). Separating from a spiritual teacher. Journal of Transpersonal Psychology, 24(1), 1-22).

DSM-IV Religious and Spiritual Problems
LESSON 2.5 Terminal and Life-Threatening Illness

Description • Associated Clinical problems • Treatment • Case Examples • WWW Library

Description

Although listed here as a religious problem, both religious and spiritual beliefs and practices can influence the ways patients react to illness. This is particularly true in the case of terminal illnesses that raise fears of physical pain, the unknown risks of dying, the threat to integrity, and the uncertainty of life after death. In addition, religious and spiritual changes often occur during terminal illness related to feelings of loss, alienation, abandonment, anger, suffering; and dependency. Issues such as forgiving others, discovering peace, discussing death, grieving, and planning the funeral often involve religion. Loss of hope and meaning of life evident in some patients, and the transitions from living to dying are essentially spiritual, and clearly not solely physiological, psychological, or social.[1]

Religious coping is one of the main strategies used to address these fears, along with exercising self-control and talking to friends and family about them. In her research on narrative life story therapy with the elderly, Viney [2] found that prayer was particularly helpful for dying persons: "Talking with God can provide opportunity to make the pain meaningful, confront the risks, confirm the integrity and give more certainty about life after death" (p. 165).

(See ICISH Research Summary of religion and the elderly)

Associated Clinical Problems

The nursing diagnostic nomenclature specifically notes that Spiritual Distress can be related to the inability to practice religious rituals, and the conflict between religious or spiritual beliefs and prescribed health regimen[3] (as illustrated in the case example below). Religious beliefs, participation in religious rituals, and affiliation with a religious community can all be affected by serious illness. Loss or questioning of faith, anger at God, guilt over "sins", and discontinuation of religious practices are frequent sequelae of terminal and life-threatening illness.

Treatment

In hospices, treatment of the terminally ill has been generally recognized to include a spiritual dimension. Hospice philosophy and accreditation standards require that spiritual care be a component of hospice care. Spirituality is useful in addressing "why me?" questions that patients frequently raise, and therapists and caregivers should actively support and facilitate spiritual thinking in terminally ill patients. Millison [4] maintains that "The caregiver needs to understand the power of spiritual beliefs in helping the patient cope with dying, and needs to be aware of the ways that spiritual striving can be helped, hindered, or undermined." Many terminal patients return to their childhood

religious beliefs and practices, while others search for new forms of spirituality. Treatment often includes working with or consulting with a religious professional. For many with a serious or life-threatening illness, the same questions and concerns arise. Conducting a Religious and Spiritual History is usually an important part of this type of clinical work. (See lesson on Assessing Spirituality)

Case Examples

A woman hospitalized with a spinal injury following an automobile accident showed symptoms consistent with a depressive disorder, and the consulting psychiatrist found that she missed the religious and spiritual practices that were part of her life before the hospitalization. The consultant recommended psychotherapy to explore her religious belief's in light of her accident, and helped her obtain a tape player so she could listen to religious music. A clergy member of her faith was contacted and made several hospital visits to provide support. The authors concluded, "Although religious interventions are not substitutes for therapeutic interventions, 'religious prescriptions' are ethically sound and may complement more traditional therapies" (p. 475).
Waldfogel S, Wolpe PR. Using awareness of religious factors to enhance interventions in consultation-liaison psychiatry. Hosp Community Psychiatry 1993 May;44(5):473-7

This is case study of a patient who experienced "losing God" as a Hodgkin's disease survivor with metastatic prostate cancer and severe coronary artery disease. His caregivers were able to provide the sense of community in which he could re-establish his faith. Health care providers do not have to be religious in order to help patients deal with a spiritual crisis. The clinical skills of compassion need to be deployed to diagnose and respond to spiritual suffering. Acknowledging and addressing anger or guilt, common sources of suffering, are essential to adjustment. Simply being there for the patient and being open to their hurt can help resolve their spiritual crisis.
Penson RT, Yusuf RZ, Chabner BA, Lafrancesca JP, McElhinny M, Axelrad AS, Lynch TJ Jr. Losing God. Oncologist 2001;6(3):286-97

WW LIBRARY of Religion and Spirituality

The WWW LIBRARY of Religion and Spirituality contains articles on spiritual issues in dying, interviews with Elizabeth Kubler-Ross MD and Stephen and Ondrea Levine.

REQUIRED QUIZ ITEM 9
Spiritual Care

According to the authors of Losing God, what factors confound spiritual aspects of cancer care? a) nebulous language b) distrust c) dogma d) all of the above.
Record your answer for later insertion into the Quiz.

References

Aldridge, D. (1993). Is there evidence for spiritual healing? Advances, 9(4), 5-21.
2 Viney, L (1993) Life stories: Personal construct therapy with the elderly.NY: Wiley.
3 Kim MJ, McFarland G, McLane A (eds): Classification of Nursing Diagnoses: Proceedings of the Fifth National Conference. St. Louis, CV Mosby, 1984.

4 Millison, M. (1988). "Spirituality and the caregiver: developing an underutilized facet of care." The American Journal of Hospice Care: 37-44.

DSM-IV Religious and Spiritual Problems
LESSON 3.1 Spiritual Emergence

Emergence versus Emergency • Extraordinary Experiences and Spiritual Emergence • Misdiagnosis of Spiritual Crises • Clinical Impact of Misdiagnoses • Types of Spiritual Problems

Emergence versus Emergency
In the DSM-IV, spiritual problems are defined as distressing experiences that involve a person's relationship with a transcendent being or force but are not necessarily related to an organized church or religious institution. Sometimes such experiences emerge from intensive involvement with spiritual practices such as meditation or yoga, as in the Meditation and Spiritual Practice type of spiritual problem.

The connection between spiritual emergences and psychological problems was first noted by Roberto Assagioli,MD who described how persons may become inflated and grandiose as a result of intense experiences associated with spiritual practices:

> Instances of such confusion are not uncommon among people who become dazzled by contact with truths too great or energies too powerful for their mental capacities to grasp and their personality to assimilate. [1] (p. 36)

Beginning in the 1960s, interest in Asian spiritual practices such as meditation, yoga, and tai chi, as well as experimentation with psychedelic drugs, triggered many mystical experiences and visionary experiencies, some of which were problematic for their practitioners.
Whereas spiritual masters have been warning their disciples for thousands of years about he dangers of playing with mystical states, the contemporary spiritual scene is like a candy store where any casual spiritual "tourist" can sample the "goodies" that promise a variety of mystical highs. When novices who don't have the proper education or guidance begin to naively and carelessly engage mystical experiences, they are playing with fire. Danger exists on the physical and psychological levels, as well as on the level of one's continued spiritual development. (*Halfway Up the Mountain: The Error of Premature Claims to Enlightenment* by Mariana Caplan)

Christina Grof and Stanislav Grof,MD, coined the term "spiritual emergency" and founded the Spiritual Emergency Network at the Esalen Institute in 1980 to assist individuals and make referrals to therapists for people experiencing psychological difficulties associated with spiritual practices and spontaneous spiritual experiences. Dr. Grof describes a spiritual emergency:

> There exist spontaneous non-ordinary states that would in the west be seen and treated as psychosis, treated mostly by suppressive medication. But if we use the

> observations from the study of non-ordinary states, and also from other spiritual traditions, they should really be treated as crises of transformation, or crises of spiritual opening. Something that should really be supported rather than suppressed. If properly understood and properly supported, they are actually conducive to healing and transformation. (Interview with Stanislav Grof,MD)

The term spiritual emergence is used to describe the whole range of phenomena associated with spiritual experiences and development from those (probably the vast majority) which are not problematic, do not disrupt psychological/social/occupational functioning and do not involve psychotherapy or any contact with the mental health system, to spiritual emergences that are full-blown crises requiring 24-hour care.

David Steindl-Rast [2], a Benedictine monk who teaches spiritual practices, has also noted that spiritual emergence can be disruptive:

> Spiritual emergence is a kind of birth pang in which you yourself go through to a fuller life, a deeper life, in which some areas in your life that were not yet encompassed by this fullness of life are now integrated . . . Breakthroughs are often very painful, often acute and dramatic.

As described in Lesson 1 Background of DSM-IV Religious or Spiritual Problem (V62.89), the impetus for proposing this new diagnostic category came from transpersonal clinicians whose initial focus was on such spiritual emergencies. Then the proposal was broadened to include religious problems.

REQUIRED QUIZ ITEM 10
Spiritual Emergency

Spiritual emergency is a term developed by C. G. Jung.
True
False
Record your answer for later insertion into the Quiz.

REQUIRED QUIZ ITEM 11
Spiritual Practices

Assagioli first proposed that spiritual practices can be associated with psychological disturbance.
True
False
Record your answer for later insertion into the Quiz.

Extraordinary Experiences and Spiritual Emergence

Some forms of spiritual emergence can take the form of extraordinary experiences, such as alien encounters and NDEs. Kenneth Ring, PhD, Professor Emeritus of Psychology at the University of Connecticut and one of the world's chief authorities on near-death

experiences, found that groups of people reporting alien encounters and NDE show similar changes over time, and many report that their lives have been radically altered on a deep spiritual level by their NDEs and encounters with aliens. They develop a heightened reverence for nature and human life, and report that their personalities are transformed as result of these experiences. He concluded that both alien abduction and NDE (and potentially other extraordinary experiences) are,

> in effect alternate pathways (Ring's emphasis) to the same type of psychospiritual transformation...that expresses itself in greater awareness of the interconnectedness and sacredness of all life and necessarily fosters a heightened ecological concern for the welfare of the planet. (*The Omega Project*)

Because of the role such extraordinary experiences as alien encounters and NDEs play in some people's spiritual lives, they are included in this course as spiritual problems. Center for Extraordinary Explorations This site covers the research and study of extraordinary experiences including: Reincarnation/Past Lives, Alien Contact, Angel Encounters, Out of Body and Near Death Experiences (OBE's and NDE's).

Misdiagnosis of Spiritual Crises

Spiritual emergencies warrant the DSM-IV diagnosis of Religious or Spiritual Problem (V62.89), even when there may be symptoms of a mental disorder present, including hallucinations and delusions. In this way, Religious or Spiritual Problem is comparable to the category Bereavement for which the DSM-IV notes that even when a person's reaction to a death meets the diagnostic criteria for Major Depressive Episode, the diagnosis of a mental disorder is not given because the symptoms result from a normal reaction to the death of a loved one. Similarly, spiritual emergencies can be disorienting and frightening. They can preoccupy the individual and lead to the performance of private rituals. All of these can present as symptoms of mental disorder. Hallucinations, delusions, anger, and interpersonal difficulties occur so frequently that they should be considered normal and expectable reactions to the spiritual emergence. Yet such spiritual problems often lead to long-term improvements in overall well-being and functioning.

The clinical literature has long recognized that some episodes with psychotic symptoms can result in improvements in an individual's functioning. Karl Menninger, MD, considered by many the father of modern Amercian psychiatry, observed that,

> Some patients have a mental illness and then get well and then they get weller! I mean they get better than they ever were . . . . This is an extraordinary and little-realized truth (Menninger cited in Silverman [3], p. 63).

Many clinicians and researchers have proposed a category for episodes with psychotic-like symptoms but which have the potential for positive outcomes:

problem-solving schizophrenics (Boisen [4])
positive disintegration (Dabrowski [5])
creative illness (Ellenberger [6])
metanoiac voyages (Laing [7])

visionary states (Perry [8])

Allen Bergin, Ph.D. [9] has observed that,

> Some religious influences have a modest impact, whereas another portion seems like the mental equivalent of nuclear energy...The more powerful portion can provide transcendent conviction or commitment and is sometimes manifested in dramatic personal healing or transformation. (p. 401)

This nuclear analogy also applies to the spiritual emergence process. It has tremendous healing power for the individual, and even for society, but can also be destructive if not channeled properly. Note that while this type of intense emergence process is discussed under this lesson on spiritual problems, a similar process occurs in religious conversion experiences, many of which involve mystical experiences (see Lesson 3.3 Mystical experiences). Unfortunately such experiences are often misunderstood by both the mental health and religious professions.

Clinical Impact of Misdiagnoses

The clinician's initial assessment can significantly influence the eventual outcome. As Greyson and Harris [10] point out, the clinician's response to a person's near-death experience can determine whether the experience is integrated and used as a stimulus for personal growth, or whether it is repressed as a bizarre event that may be a sign of mental instability. Similarly, with mystical experience, negative reactions by professionals can intensify an individual's sense of isolation and block his or her efforts to seek assistance in understanding and assimilating the experience.

Individuals undergoing powerful religious and spiritual experiences are at risk for being hospitalized as mentally ill. Even many religious professionals seem unable to make the distinction between genuine and pathological religious experiences.

> If a member of a typical congregation were to have a profound religious experience, its minister would very likely send him or her to a psychiatrist for medical treatment. (Stanislav Grof, Beyond the brain: Birth, death and transcendence in psychotherapy).

One person who had had a near-death experience reported:

> "I tried to tell my minister, but he told me I had been hallucinating, so I shut up" (Raymond Moody Life After Life: The Investigation of a Phenomenon — Survival of Bodily Death p 86).

If tumultuous episodes with growth potential and those which indicate a mental disorder could be differentiated, the prognosis of individuals with spiritual emergence problems could be improved by providing appropriate treatment consistent with their need to express and integrate the physical, psychopathological, and spiritual symptoms.
(see Lesson V Differential Diagnosis)

References

1 Assagioli, R. (1989). Self-realization and psychological disturbances. In S. Grof & C. Grof (Eds.), Spiritual emergency: When personal transformation becomes a crisis, Los Angeles: Tarcher.
2 David Steindl-Rast cited in Bragdon, E. (1993). A sourcebook for helping people with spiritual problems. Aptos, CA: Lightening Up Press. p. 18.
3 Silverman, J.(1967). Shamans and acute schizophrenia. American Anthropologist, 69(1), 21-31.
4 Boisen, A. T.(1962). The exploration of the inner world. New York: Harper and Row.

5 Dabrowski, K. (1964). Positive disintegration. Boston: Little Brown.

6 Ellenberger, H. (1970). The discovery of the unconscious. New York: Basic Books.
7 Laing, R.D. (1972). Metanoia: Some experiences at Kingsley Hall, London. In H. M. Ruitenbeck (Eds.), Exploring Madness (pp. 113-121). Monterey, CA: Brooks/Cole.

8 Perry, J. (1974). The far side of madness. Englewood Cliffs, NJ: Prentice Hall.
9 Bergin, A. (1991). Values and religious issues in psychotherapy and mental health. American Psychologist, 46(4), 394-403.
10Greyson, B., & Harris, B. (1987). Clinical approaches to the near-death experience. Journal of Near-Death Studies, 6(1), 41-52.

DSM-IV Religious and Spiritual Problems
LESSON 3.2 Typology of Spiritual Problems

Types of Spiritual Problems

The reliable recognition of different types of spiritual problems is in its infancy. There is considerable overlap in terminology in all the proposed taxonomies. Despite the human desire for order, nature does not usually divide phenomena into neat categories. I have seen people in spiritual emergencies whose episode combined elements from more than one of the types described in this course. One case I wrote about in *Myths in Mental Illness* had elements of both mystical and a visionary experiences. My own spiritual emergency had elements from both shamanic crisis and mystical experience.

Yet there is sufficient regularity in these self-reports to establish phenomenologically-based types determined by the way people have described the experiences. There is no claim that these experiences are "objectively true."

In this course, the following typology is used:

- Mystical experiences
- Near-death experiences
- Meditation and spiritual practice
- Psychic experiences
- Visionary experiences
- Shamanic experiences
- Alien Encounter Experiences
- Possession experiences

Other typologies have been developed by Stanislav and Christina Grof and the Spiritual Emergency Network.

DSM-IV Religious and Spiritual Problems
LESSON 3.3 Mystical Experience

Description • Mystical Experience and Psychopathology • Associated Clinical problems • Therapy • Case Examples • WWW Library

Descriptions
The definitions of mystical experience used in research and clinical publications vary considerably, ranging from

> "upheaval of the total personality"
> (Neumann, E. in *The Mystic Vision*)

to definitions which include

> "everyday mysticism"
> (Scharfstein, B. *Mystical Experience*)

For clinical assessment, the mystical experience can be seen as a transient, extraordinary experience marked by:

> feelings of unity
> sense of harmonious relationship to the divine
> euphoria
> sense of noesis (access to the hidden spiritual dimension)
> loss of ego functioning
> alterations in time and space perception
> sense of lacking control over the event.
> (see Several Definitions of Mysticism)

William James saw mystical experience as being at the core of religion, and believed that such experiences led to the founding of the world's religions.

> One may say truly, I think, that personal religious experience has its root and center in mystical states of consciousness. (*Varieties of Religious Experience*)

Mystical Experiences and Psychopathology
Surveys assessing the incidence of mystical experience in the general population indicate that it has been rising. during the past few decades. Now more than half the population polled answered yes to the Gallup Poll question:

> Have you ever been aware of, or influenced by, a presence or a power — whether you call it God or not — which is different from your everyday self?
> 1973: 27%
> 1986: 42%
> 1990: 54%
> (Gallup [1], [2])

Given that most of the adult population report such experiences, they are clearly normal rather than pathological phenomena. A recent survey found that most clinicians do not currently view mystical experiences as pathological [3]. To some degree this reflects a change, partly attributable to Abraham Maslow, Ph.D., who was a founder of humanistic psychology in the 1960s, and then went on to found transpersonal psychology. He described the mystical experience as an aspect of everyday psychological functioning:

> It is very likely, indeed almost certain, that these older reports [of mystical experiences], phrased in terms of supernatural revelation, were, in fact, perfectly natural, human peak experiences of the kind that can easily be examined today. (Abraham Maslow *Religions, Values, and Peak Experience*s p. 20)

Yet historically, mental health theory and diagnostic classification systems have tended to either ignore or pathologize such intense religious and spiritual experiences. Some clinical literature has described the mystical experience as symptomatic of

> ego regression
> borderline psychosis
> a psychotic episode
> temporal lobe dysfunction
> (see Lukoff D, Lu F, Turner R. Toward a more culturally sensitive DSM-IV: Psychoreligious and psychospiritual problems)

Freud reduced the "oceanic experience" of mystics to "infantile helplessness" and a "regression to primary narcissism" in *Civilization and Its Discontents*.

In contrast to Freud, other theorists have viewed mystical experiences as a sign of health and a powerful agent of transformation, including C.G. Jung, (see *Psychology and Religion*) and Evelyn Underhill (see *Mysticism: The Nature and Development of Spiritual Consciousness*).

In addition, studies have found that people reporting mystical experiences scored lower on psychopathology scales and higher on measures of psychological well-being than controls. (see The Psychology of Religion: An Empirical Approach by Ralph W. Hood, Editor).
Many contemporary religious groups, such as the followers of the Guru Maharaji, cultivate mystical experiences,
Mystical experiences, analogous to an acute circumscribed hallucinatory episode, were found to be a central factor in the conversion of some of the adherents to the Divine Light Mission.[3], p. 281)

> These events typically lasted one to three hours. Such behavior and states of mind appear psychotic, but they take place in a cultural context which promotes and guides such experiences. Similarly Ram Dass, a former psychologist turned spiritual teacher, describes individuals in a "god-intoxicated" state undergoing a training program for mystical experience under the close supervision of a master.

Associated Clinical Problems

Case studies document instances where mystical experiences are disruptive and distressing. This is one type of spiritual problem that therapists see regularly. In a survey, psychologists reported that 4.5% of their clients over the past 12 months brought a mystical experience into therapy (4).

Mystical experiences can be overwhelming for individuals who don'talready have a strong sense of self. They can become frightened and confused by the sudden influx of spiritual consciousness. Roberto Assagioli, MD, known for being the founder of psychosynthesis, described this clinical problem:

> The personality is unable to rightly assimilate the inflow of light and energy. This happens, for instance,
> when the intellect is not well coordinated and developed
> when the emotions and the imagination are uncontrolled
> when the nervous system is too sensitive, or
> when the inrush of spiritual energy is overwhelming in its suddenness and intensity.
> (Self-realization and psychological disturbances in Spiritual Emergency: When Personal Transformation Becomes a Crisis by Stanislav Grof and Christina Grof, p. 34-5)

However, there are also several specific similarities between self-reported descriptions of mystical and psychotic experiences.

> Feeling of being transported beyond the self to a new realm
> Feeling of communion with the 'divine'
> Sense of ecstasy and exultation
> Heightened state of awareness
> Loss of self-object boundaries
> Powerful sense of noesis
> Distortion of time-sense
> Perceptual changes (synesthesia, dampening, or heightening)
> Hallucinations
> (Buckley, P. Mystical experience and schizophrenia)

REQUIRED QUIZ ITEM 12
Themes

A feeling of communion with the divine occurs
a) more often in mystical experiences b) more often in psychosis c) in both mystical experiences and psychosis
Record your answer for later insertion into the Quiz.

Hallucinations in mystical experiences are more often visual than auditory. In both states, the sensation of seeing and being enveloped in light is common.

A computerized content analysis comparing written passages describing schizophrenia, hallucinogenic drug experiences, and mystical experiences with autobiographical accounts as controls also provides guidance for differential diagnosis:

> Schizophrenic subjects emphasize illness/deviance themes
> Hallucinogenic accounts emphasize altered sensory experience
> Mystical accounts focus on religious/spiritual issues
> Normal control subjects emphasize adaptive and interpersonal themes
> (Oxman TE, Rosenberg SD, Schnurr PP, Tucker GJ, Gala G, The language of altered states)

REQUIRED QUIZ ITEM 13
Themes

Oxman et al. in The language of altered states found that illness themes are more characteristic of mystical experiences than schizophrenic episodes.
True
False
Record your answer for later insertion into the Quiz.

This strongly suggests that content can be used as a guide in differential diagnosis. Phenomenological overlap with one of the types of spiritual problems is Criterion 1 of the differential diagnostic criteria presented in Lesson 5

One of the main risks observed following ecstatic mystical experiences is ego inflation, in which an individual develops highly grandiose beliefs or even delusions about their own spiritual stature and attainment. Many theorists have seen this as an "occupational risk" associated with seeking spiritually transformative experience.

> The very calling contains the scent of inflation — or as it is called in Zen, the stink of enlightenment.
> (Gary Rosenthal in *Spiritual Choices: The Problems of Recognizing Authentic Paths to Inner Transformation*)

Jung also observed inflation as a risk of spiritual practices:

> The state we are discussing involves an extension of the personality beyond individual limits, in other words a state of being puffed up...The inflation has nothing to do with the kind of knowledge, but simply and solely with the fact that any new knowledge can so seize hold of a weak head that he no longer sees and hears anything else. He is hypnotized by it and instantly believes he has solved the riddle of the universe.
> *Portable Jung*

I certainly experienced this inflation in my spiritual crisis, believing for a while that I was a reincarnation of Buddha and Christ. (see my case history)

Treatment

As with other types of spiritual emergency, individuals in the midst of intense mystical experiences have been hospitalized and medicated, when less restrictive and more health-promoting interventions could have been utilized. Some have suggested that the presence of a mystical experience is a contraindication for medication:

> The phenomenological overlap in some aspects of the acute mystical experience and acute schizophrenia . . . suggests that the presence of similar subjective phenomena in some acute schizophrenics might be a possible marker of patients who should not receive medication.(Mystical experience and schizophrenia p. 430)

Thus the most crtical component of clinical care is to recognize and diagnose episodes involving mysitical episodes. Therapy to help a person integrate a mystical experience should follow the guidelines suggested in Lesson 6 .

Case Examples

Canadian psychiatrist Richard Bucke
His personal mystical experience as recounted in his influential book in the field of psychology of religion, Cosmic Consciousness.
Myths in Mental Illness by David Lukoff,PhD
Case of Howard, hospitalized while on a Mental Odyssey.

WWW LIBRARY of Religion and Spirituality

The WWW LIBRARY of Religion and Spirituality contains articles on mystical experiences and guides to online resources on mysticism.

References

1 Gallup, G., (1987) The Gallup poll: Public Opinion 1986., Wilmington, DE: Scholarly Resources.
2 Gallup 1990 This survey data was obtained directly from the Gallup Organization. Source Document: Gallup Poll-A.I.P.O. JUN 1990.
3 Buckley, P. and Galanter, M. (1979). Mystical experience, spiritual knowledge, and a contemporary ecstatic religion. British Journal of Medical Psychology, 52, 281-289.
4 Lannert, J. (1991). "Resistance and countertransference issues with spiritual and religious clients." Journal of Humanistic Psychology 31(4): 68-76.

DSM-IV Religious and Spiritual Problems
LESSON 3.4 Near-Death Experience

Description • NDE and Psychopathology • Associated Clinical Problems • Treatment • Case Examples • WWW Library

Description
The near-death experience (NDE) is a subjective event experienced by persons who come close to death, who are believed dead and unexpectedly recover, or who confront a potentially fatal situation and escape uninjured. Since Raymond Moody, MD first focused public attention in 1975 on the near-death experience in his book, Life After Life. Since then the NDE has been the focus of considerable scientific research.

The NDE is a clearly identifiable psychological phenomenon that includes:

A characteristic temporal sequence of stages
peace and contentment
detachment from physical body
entering a transitional region of darkness
seeing a brilliant light
passing through the light into another realm of existence
A cluster of subjective components
strong positive affect
dissociation from the physical body
transcendental or mystical elements

The person often feels unconditionally accepted and forgiven by a loving source. Life review is also common, and the person returns with a mission or "vision," believing that there is still more to be done in this life.

Modern medical technology has resulted in many persons experiencing NDEs. Near-death experiences are reported by 35% of individuals who come close to death. Gallup Polls estimates that about 5% of the adult American population, approximately 13 million American adults, have had a NDE with at least some of the features described above, making it a clinically significant and pervasive phenomenon. (See The International Association for Near-Death Studies)

NDE and Psychopathology
In the proposal to the Task Force on DSM-IV for the new diagnostic category, Religious or Spiritual Problem, the NDE was used as an example of a spiritual problem that warrants clinical attention, but is not a mental disorder. The non-pathological nature of the NDE is documented by the growing literature on its after-effects — in particular, the

positive attitude and value changes, the personality transformation, and spiritual development that often follow such an experience.

The typical near-death survivor emerges from his experience with a heightened sense of appreciation for life, determined to live life to the fullest. He has a sense of being reborn and a renewed sense of individual purpose in living. . .He is more reflective and seeks to learn more about this core experience. He feels himself to be a stronger, more self-confident person and adjusts more easily to the vicissitudes of life. The things that he values are love and service to others; material comforts are no longer so important. He becomes more compassionate toward others, more able to accept them unconditionally. He has achieved a sense of what is important in life and strives to live in accordance with his understanding of what matters. (Kenneth Ring, *Heading Toward Omega: In Search of the Meaning of the Near-Death Experience* p. 157-8)

Kenneth Ring, PhD has conducted studies on NDE on which this summary is based. His research found these changes occur within 5 years and are stable over time. (See After-effects of Near-death States for a review of the extensive research documenting psychological and physiological changes.)

Charles Tart, PhD posits that the experience of existing in some form that seems partially or fully independent of the physical body (as occurs in NDE and other altered states of consciousness) constitutes the most direct knowledge of survival an individual may have. While not the subject of this course, NDEs present profound challenges for the study of consciousness and reveal issues of deep significance for the life of the individual and for humankind in general.

Associated Clinical Problems
Despite generally positive outcomes, significant intrapsychic and interpersonal difficulties frequently arise in the wake of an NDE.

Intrapsychic problems associated with NDE include:

anger or depression related to losing the near-death state
difficulty reconciling the NDE with previous religious beliefs, values or lifestyle
becoming overly identified with the experience
the fear that the NDE might indicate mental instability

Interpersonal problems associated with NDE include:

difficulty reconciling attitudinal changes with the expectations of family and friends
a sense of isolation from those who have not had a similar experience;
a fear of ridicule or rejection from others
difficulty communicating the meaning and impact of the NDE
difficulty maintaining previous life roles that no longer carry the same significance

> difficulty reconciling limited human relationships with the unconditional relationships experienced during the NDE
> (Greyson B, The near-death experience as a focus of clinical attention)

Some NDEs become very distressing and meet the criteria for DSM-IV Adjustment Disorder. (Greyson B, Bush NE, Distressing near-death experiences)

In the immediate aftermath of an NDE, many individuals struggle with a fear of mental instability and/or a fear of rejection and ridicule by family and friends. One person reported, "I've lived with this thing [NDE] for three years and I haven't told anyone because I don't want them to put the straight jacket on me."Another found that, "After this happened to me [an NDE], and I tried to tell people, they just automatically labeled me as crazy" (Raymond Moody *Life After Life: The Investigation of a Phenomenon — Survival of Bodily Death*, p. 86). Many individuals did not discuss the NDE with friends or professionals for fear of being rejected, ridiculed, or regarded as psychotic or hysterical.

In addition, individuals who shared their experiences with professionals have often received negative reactions. Raymond Moody cited these examples: One woman stated, "I tried to tell my minister, but he told me I had been hallucinating, so I shut up" (p. 86). A surgical patient recounted that, "I tried to tell my nurses what had happened when I woke up, but they told me not to talk about it, that I was just imagining things" (p 87). *Life After Life: The Investigation of a Phenomenon — Survival of Bodily Death*,

Long term adjustment to a near-death experience can also present problems. Greyson [1] described such a case:

> A 24 year-old graduate student in geology had a near-death experience during a near-drowning when he was 17. In the intervening 7 years, he experienced some unusual psychological phenomena that eventually prompted him to seek treatment. His NDE included a life review involving many events from his childhood along with several scenes that he could not recognize. After a few of these scenes came to pass exactly as they had appeared in his life review, he became concerned about some very painful scenes that had not yet happened and which he felt were destined to happen someday. He sought counseling for his anxiety about these seemingly inevitable events and his despair at losing control over his fate.

In this case, the client's psychological conflicts were not attributable to a mental disorder, but were rather a longer-term manifestation of the psychological upheaval surrounding his earlier NDE. The issue of the meaning of the patient's clairvoyance (seeing into the future) raised questions for the patient about his values ("losing control over his fate"), thus warranting a Religious or Spiritual Problem diagnosis.

Treatment
Spiritual experiences that occur during an NDE are often a prominent issue in therapy. Yet prior religious beliefs do not affect either the likelihood or the depth of the near-death experience. An atheist is as likely to have a life-changing NDE as a devoutly religious person.

Fortunately, the many published scientific articles and first person accounts have resulted in greater sensitivity to these experiences. NDEs are recognized as fairly common occurrences in modern ICUs, as is the need to differentiate between NDEs and ICU psychoses (which do occur often as a side-effect of aggressive treatments) . With this increased awareness, ICUs are less likely to "treat" NDEs with antipsychotic medication. Bruce Greyson, MD, expects that this clinical problem will be given greater attention in the future:

The inclusion of this new diagnostic category in the DSM-IV permits differentiation of NDEs and similar experiences from mental disorders and may lead to research into more effective treatment strategies. (The near-death experience as a focus of clinical attention, p. 327)
Therapists working with persons who have had an NDE can utilize the interventions described in Lesson 6.

Case Examples
The International Association for Near-Death Studies site contains many case examples of NDEs, including one entitled My Spiritual Enlightenment.

WWW LIBRARY on Religion and Spirituality
The WWW Library on Spirituality and Religion contains summaries of scientific findings on the aftereffects of NDEs, religious beliefs concerning death and afterlife, and interpretations of NDEs by different religious groups. Also personal accounts and NDE organizations.

References
1 Greyson, B. and Harris, B. (1987). Clinical approaches to the near-death experience, Journal of Near-Death Studies, 6(1), 41-52.

REQUIRED QUIZ ITEM 14
Medical Technology

Which of the following types of spiritual problems is occurring more frequently due to advances in medical technology.

a) UFO abduction b) Kundalini c) NDE d) Psychic Experiences

Record your answer for later insertion into the Quiz.

DSM-IV Religious and Spiritual Problems
LESSON 3.5 Meditation and Spiritual Practices

Description • Associated Clinical problems • Treatment • Case Examples • WWW Library

Description

Problems Related to Spiritual Practices

In the DSM-IV, spiritual problems are defined as distressing experiences that involve a person's relationship with a transcendent being or force, but are not necessarily related to an organized church or religious institution. Sometimes such experiences result from intensive involvement with spiritual practices such as yoga. The impetus for proposing this new diagnostic category came from transpersonal clinicians whose initial focus was on crises triggered by meditation and other spiritual practices.

The connection between spiritual practices and psychological problems was first noted by Assagioli [1] who described how persons may become inflated and grandiose as a result of intense spiritual experiences:

> Instances of such confusion are not uncommon among people who become dazzled by contact with truths too great or energies too powerful for their mental capacities to grasp and their personality to assimilate (p. 36).

Beginning in the 1960s, interest in Asian spiritual practices such as meditation, yoga, and tai chi, and experimentation with psychedelic drugs led to an increase in the number of people experiencing related spiritual problems and crises.

> When novices who don't have the proper education or guidance begin to naively and carelessly engage mystical experiences, they are playing with fire. Danger exists on the physical and psychological levels, as well as on the level of one's continued spiritual development. Whereas spiritual masters have been warning their disciples for thousands of years about the dangers of playing with mystical states, the contemporary spiritual scene is like a candy store where any casual spiritual "tourist" can sample the "goodies" that promise a variety of mystical highs. (*Halfway Up the Mountain: The Error of Premature Claims to Enlightenment* by Mariana Caplan)

Stuart Sovatsky, PhD, Director of the Kundalini Clinic, notes that difficulties can accompany valid spiritual experiences: "That some problems arise as a result of the most auspicious of spiritual experiences, long documented in diverse religions, must, in such cases, also be considered. (*Word from the Soul: Time, East/West Spirituality, and Psychotherapeutic Narrative*)

Stanislav and Christina Grof coined the term "spiritual emergency" and founded the Spiritual Emergency Network in 1980 to identify individuals experiencing psychological difficulties associated with spiritual practices and spontaneous spiritual experiences. SEN also makes referrals to therapists for such problems.

> There exist spontaneous non-ordinary states that would in the west be seen and treated as psychosis, treated mostly by suppressive medication. But if we use the observations from the study of non-ordinary states, and also from other spiritual traditions, they should really be treated as crises of transformation, or crises of spiritual opening. Something that should really be supported rather than suppressed. If properly understood and properly supported, they are actually conducive to healing and transformation. (Interview with Stanislav Grof)

Meditation-Related Problems

Intensive meditation practices can involve spending many hours each day in meditation for weeks or months meditating. Asian traditions recognize a number of pitfalls associated with intensive meditation practice, such as altered perceptions that can be frightening, and "false enlightenment," associated with delightful or terrifying visions. Epstein (1990)[2] describes a "specific mental disorder that the Tibetans call 'sokrlung':

> a disorder of the 'life-bearing wind that supports the mind' that can arise as a consequence...of strain[ing] too tightly in an obsessive way to achieve moment-to-moment awareness. (p. 27)

When Asian meditative practices are transplanted into Western contexts, the same problems can occur. Anxiety, dissociation, depersonalization, altered perceptions, agitation, and muscular tension have been observed in western meditation practitioners (Walsh R, Roche L. Precipitation of acute psychotic episodes by intensive meditation in individuals with a history of schizophrenia).. Yet Walsh and Roche point out that "such changes are not necessarily pathologic and may reflect in part a heightened sensitivity" (p. 1086). The DSM-IV emphasizes the need to distinguish between psychopathology and meditation-related experiences:

> Voluntarily induced experiences of depersonalization or derealization form part of meditative and trance practices that are prevalent in many religions and cultures and should not be confused with Depersonalization Disorder. (p. 488)

REQUIRED QUIZ ITEM: 15
Meditation
Intensive meditation practices can lead to
a) feelings of depersonalization b) anxiety c) disorientation d) all of the above
Record your answer for later insertion into the Quiz.

Yoga and Kundalini

In the Hindu tradition, kundalini is spiritual energy presumed to reside at the base of the spine. When it is awakened by practices such as yoga, it rises like a serpent up the spine,

and opens the chakras' psychic centers situated along the spine from the tailbone to the top of the head.

> As each chakra opens, new levels of consciousness are revealed. Since the consciousness of most people is fairly restricted, the opening of the chakras is accompanied by consciousness expansion and purification of the limitations or impurities that correspond to each chakra.
> (Brant Cortright, PhD, Psychotherapy and Spirit, p. 161)

As kundalini rises, it is associated with physical symptoms including:

> sensations of heat
> tremors
> involuntary laughing or crying
> talking in tongues
> nausea, diarrhea or constipation
> rigidity or limpness
> animal-like movements and sounds

Kundalini arousal most commonly occurs as an unintentional side-effect of yoga, meditation, qi gong. or other intensive spiritual practices. Some theorists consider psychotherapy, giving birth, unrequited love, celibacy, deep sorrow, high fever, and drug intoxication to be triggers. Some believe kundalini awakening can occur spontaneously without apparent cause.

Bonnie Greenwell, Ph.D., is a transpersonal therapist whose work focuses on kundalini awakening problems. I concur with her view that the term kundalini is most applicable to problems specifically associated with spiritual practices. When Dr. Greenwell was queried about a case which included symptoms such as shaking at night, which can occur in kundalini awakening, she responded,

> If the person had presented me with a description of an awakening experience, if he did exercises such as meditation, yoga, or a martial art regularly, or if he experienced strong meditative states where he went beyond concentration into stillness or a sense of unity, then I would be more likely to consider it Kundalini. (Kundalini Quest)

Associated Clinical Problems

Derealization and depersonalization have been reported with intensive meditation. Usually the symptoms cease if the practice is discontinued, as in the case example in the Treatment section below. Meditation has been reported to trigger psychotic episodes in schizophrenic patients with active psychotic symptoms.

Walsh R, Roche L. Precipitation of acute psychotic episodes by intensive meditation in individuals with a history of schizophrenia. Am J Psychiatry. 1979 Aug;136(8):1085-6

However this course author developed a multimodal holistic health program for schizophrenic patients at a state psychiatric hospital which incorporated meditation without any adverse effects, and also used meditation with patients at the San Francisco VA for 14 years.
Lukoff D, Wallace CJ, Liberman RP, Burke K. A holistic program for chronic schizophrenic patients. Schizophr Bull. 1986;12(2):274-82.

Kundalini awakening can resemble many disorders, medical as well as psychiatric. The symptoms can mimic conversion disorder, epilepsy, lower back problems, multiple sclerosis, heart attack or pelvic inflammatory syndrome. The emotional reaction to the awakening of kundalini can be confused with disorders involving anxiety, depression, aggression, and organic syndromes. Bonnie Greenwell, Ph.D. did her dissertation study on individuals who had a kundalini awakening. She summarizes the clinical issues that she observed in her book, *Energies of Transformation: A Guide to the Kundalini Process.* She describes a number of key features of kundalini awakening which were experienced by people in her study:

Pranic movements or kriyas
Prana is the Hindu word for vital energy. As intense energy moves through the body and clears out physiological blocks, some people experience intense involuntary, jerking movements of the body, including shaking, vibrations, spasm and contraction.
Yogic Phenomena
Some people find themselves performing yogic postures or hand mudra gestures which they have never learned or could not do in a normal state of consciousness. Unusual breathing patterns may appear with either very rapid or slow, shallow breathing.
Physiological Symptoms
Kundalini awakening often generates unusual physiological activity which can present as heart, spinal, gastrointestinal, or neurological problems. Internal sensations of burning, hypersensitivity to sensory input, hyperactivity or lethargy, great variations in sexual desire, and even spontaneous orgasm have been reported.
Psychological Upheaval
Emotions can swing from feelings of anxiety, guilt, and depression (with bouts of uncontrollable weeping) to compassion, love, and joy.
Extrasensory Experiences
Some people experience visions of lights, symbols, spiritual entities. Auditory sensations may include hearing voices, music, inner sounds or mantras. There may also be disruption of the proprioceptive system, with loss of a sense of self as a body, or an out of the body experience.
Psychic Phenomena
A person may experience precognition, telepathy, psychokinesis, awareness of auras and healing abilities.
Mystical States of Consciousness
A person may shift into altered states of consciousness where they directly perceive the unity underlying the world of separation and experience a deep peace and serenity. (see Karin Hannigan, PhD for additional description)

The sudden onset of these experiences led many in Greenwell's study to become confused and disoriented. Kundalini awakening is probably the most common type of spiritual emergency. The Spiritual Emergence Network Newsletter reported that 24% of their hotline calls concerned kundalini awakening experiences. [3]
The DSM-IV, in Appendix I: Culture Bound Syndromes, includes "qi-gong psychotic reaction," which is similar to kundalini awakening. (Qi-gong or chi kung is an ancient Chinese moving meditation practice).
Unlike those suffering from psychosis, individuals experiencing kundalini, typically are

> much more objective about their condition
> communicate and cooperate well
> show interest in sharing their experiences with open-minded people
> seldom act out
> (Stanislav and Christina Grof, *Spiritual Emergency: When Personal Transformation Becomes a Crisis)*

Lee Sannella, MD's book Kundalini: Psychosis or Transcendence (Copyright © 1976) is online for free downloading.

Treatment
Treatment involves discontinuation of the spiritual practice, at least temporarily, and engaging in alternative "grounding" activities. Kornfield (1993), a psychologist and experienced meditation teacher, described what he termed a spiritual emergency that took place at an intensive meditation retreat he was leading.

> An "overzealous young karate student" decided to meditate and not move for a full day and night. When he got up, he was filled with explosive energy. He strode into the middle of the dining hall filled with 100 silent retreatants and began to yell and practice his karate maneuvers at triple speed. Then he screamed, "When I look at each of you, I see behind you a whole trail of bodies showing your past lives." As an experienced meditation teacher, Kornfield recognized that the symptoms were related to the meditation practice rather than signs of a manic episode (for which they also meet all the diagnostic criteria except duration). The meditation community handled the situation by stopping his meditation practice and starting him jogging, ten miles in the morning and afternoon. His diet was changed to include red meat, which is thought to have a grounding effect. They got him to take frequent hot baths and showers, and to dig in the garden. One person was with him all the time. After three days, he was able to sleep again and was allowed to started meditating again, slowly and carefully.
> (adapted from *A Path With Heart : A Guide Through the Perils and Promises of Spiritual Life* by Jack Kornfield pp. 131-132)

While in some cases, the psychological upheaval is so acute that it resembles a psychotic episodes, medication can further complicate the process (see medication). Dr. Greenwell suggests that it would be therapeutic for the individual to study some of the Eastern theories and descriptions of kundalini. Her other recommendations follow the basic

treatment guidelines for all spiritual emergence processes (see Lesson 6.1 Spiritual Crises),

> Look for ways to discharge this energy by running, exercising, gardening, or working with something solid, like wood or clay. I would suggest doing a regular meditation practice, and letting the process develop and teach him. . .The best support is a balanced lifestyle and a commitment to live one's life in alignment with the vision it brings — that is, if you have a heart-opening or a visionary experience, instead of being attached to holding onto it, ask yourself what you can bring into the world as service to it. . .Think of it as if the amps have been raised in your electrical system. This is why balance, taking care of ourselves, being in nature, and regular physical exercise all help. We may have to change old patterns to meet the invitation to a new kind of energy flow and engagement with spirit in our lives. (Nighttime Shakes)

She also suggests creative activities such as art, music, or writing for expressing it. Since this type of spiritual problem is related to a type of practice, consultation with a teacher of the practice who also has mental health training would be advisable. Dr. Greenwall indicates that learning some basic yogic breathing practices, under the supervision of a knowledgeable yoga teacher, can help guide this energy.

REQUIRED QUIZ ITEM 16
Treatment
A person experiencing symptoms related to a spiritual practice should be told to continue their practice until the symptoms subside.
True
False
Record your answer for later insertion into the Quiz.

Case Examples
Kundalini Awakens — A Personal Account
by Ruth Trimble
Overzealous Meditator
by Jack Kornfield,PhD

WWW LIBRARY on Religion and Spirituality
The WWW LIBRARY on Religion and Spirituality contains articles on meditation and kundalini and guides to online resources on meditation..
Meditation in Clinical Practice -an Internet Guided Learning course which goes into more depth about the effects of meditation and its clinical applications.

References
1 Assagioli, R. (1989). Self-realization and psychological disturbances. In S. Grof & C. Grof (Eds.), Spiritual emergency: When personal transformation becomes a crisis, Los Angeles: Tarcher.

2 Epstein, S. (1979). Natural healing processes of the mind: I. Acute schizophrenic disorganization. Schizophrenia Bulletin, 5(2), 313-321.
3 Lukoff, D. The SEN Hotline: Results from a telephone survey. SEN Newsletter, March 1988.

IGL 251: DSM-IV Religious and Spiritual Problems
LESSON 3.6 Psychic Experiences

Description • Psychic Experiences & Psychopathology • Associated Clinical problems • Treatment • Case Examples • WWW Library

Description
Psychic experiences are extrasensory occurrences, such as:

clairvoyance (visions of past, future, or remote events)
telepathy (communication without apparent physical means)
poltergeist phenomena (physical disturbances in a house with no apparent physical cause)
precognition (visions or dreams that provide formerly unknown information)
Synchronistic events (meaningful coincidences of two apparently (in terms of cause and effect) non-related events)

Psychic experiences occur in other forms of spiritual emergences, such as shamanic crises, kundalini, and mystical experiences, but in the Psychic Experience type of spiritual problem, psychic events are the central feature of the person's experience.

Psychic experiences are also associated with many spiritual paths and altered states of consciousness. In yoga and Buddhism, these are referred to as siddhis. The Yoga Sutras of Patanjali and the Buddhist Abhidhamma include specific practices that are purported to lead to the development of psychic abilities, but practitioners are taught that these are distractions from the true path of spiritual development.

While the scientific status of psychic experiences has been the subject of much debate, there is no question that most people have such experiences. Gallup polls [1] show that a majority of the population have extrasensory experiences, and the percentage is increasing (from 58% in 1973 to 67% in 1986). Unfortunately both sensationalism (in tabloid media) and commercialism (fee-based psychic hot lines) are associated with this topic, but extrasensory perception has also been the subject of scientific research for 100 years, and continues to this day. (see Rhine Center for a history of scientific research)

Psychic Experiences and Psychopathology
Some types of psychic experiences are considered to be abilities, such as Medical Intuition: The ability to perceive the subtle energy around another individual. This psychic ability is taught in workshops by therapists like Caroline M. Myss, PhD who is a medical intuitve.

Jerome Frank, PhD, former Professor of Psychiatry at Johns Hopkins and considered one of the most influential theorists about psychotherapy, also considers psychic abilities to play a role in psychotherapy:

> My own hunch, which I mention with some trepidation, is that the most gifted therapists may have telepathic, clairvoyant, or other parapsychological abilities. . .They may, in addition, possess something. . .that can only be termed "healing power." Any researcher who attempts to study such phenomena risks his reputation as a reliable scientist, so their pursuit can be recommended only to the most intrepid. The rewards, however, might be great. (*Persuasion and Healing: A Comparative Study of Psychotherapy*)

However, psychic experiences are also reported by people in psychotic and dissociative experiences. Thus, differential diagnosis is a key issue. The therapist needs to know about the variety of ways that psychic phenomena can manifest and how people cope with them

To acquaint yourself with the range of psychic experiences, visit the About.com story archives, which has dozens of first person accounts of "normal" people's psychic experiences such as telepathy and clairvoyance.

Associated Clinical Problems
Confusion and the fear that "I'm going crazy" are common reactions to spontaneous psychic experiences. In Psychics' Fears of Psychic Powers, Charles T. Tart, PhD. has described how people can become quite fearful upon the awakening of their intuitive abilities. People also report feeling isolated from others because theyare afraid to talk about these experiences with their friends and family.

Treatment
Many people who have had psychic experiences are able to integrate them without any professional help. But some do seek out a therapist for assistance in understanding such events and coping with their reactions to them. Arthur Hastings, PhD [1]suggests that,

The focus of this counseling, given therapeutic purposes, rather than research purposes only, should be to assist the person to a experience of balance, integration, and judgment relating to apparent or genuine parapsychological experience. (p. 143)

He describes 7 steps in working with someone who has had a disturbing psychic experience:

> Ask the person to describe the experience or events
> Listen fully and carefully, without judging
> Reassure the person that the experience is not "crazy" or "insane" (if this is appropriate)
> Identify or label the type of event

Give information about what is known about this type of event
Where possible, develop reality tests to discover if the event is genuine or if there are non-psychic alternative explanations
Address the psychological reactions that result from the experience

This approach is very congruent with the treatment approach outlined in Lesson 6.2 Psychotherapy, particularly the therapist's role in normalizing spiritual emergence experiences.

Case Examples
The Terrifying Amherst Poltergeist

About.com story archives has dozens of first person accounts of people's paranormal experiences.

WWW Library of Religion and Spirituality
The WWW Library of Religion and Spirituality contains articles on parapsychology, interviews with Francis Vaughan, PhD on awakening intutition and with Arthur Hastings, PhD on channeling, as well as a link to the Professional Parapsychological Association.

References
1 Gallup, G., (1987) The Gallup poll: Public Opinion 1986., Wilmington, DE: Scholarly Resources.
2 Hastings, A. (1983). "A counseling approach to parapsychological experience." Journal of Transpersonal Psychology 15 (2): 143-167. p. 143.

REQUIRED QUIZ ITEM 17
Psychic Experiences

Psychic experiences are an indicator that a person is in the midst of a psychotic episode.

True
False

Record your answer for later insertion into the Quiz.

REQUIRED QUIZ ITEM 18
Therapy with Psychic Experiences

In therapy, a person's psychic experiences

a) should be put on extinction b) should be considered a spiritual experience c) should be investigated in therapy for what it means to the client

DSM-IV Religious and Spiritual Problems
LESSON 3.7 Visionary Experiences

Description • Associated Clinical problems • Treatment • Case Examples • WWW Library

Description

Visionary experiences involve the activation of the unconscious archetypal psyche which then dominates consciousness. This is the part of the mind which produces dreams and also myths. Anthony Wallace, PhD [1] an anthropologist, has documented several cases where individuals underwent what seemed to be psychotic episodes and subsequently developed an entirely new mythology and way of life for their social group. For example, in late 1700, Handsome Lake created a new society among the Iroquois Indians on the basis of the visions he had while incapacitated for 6 months.

Visionary experiences have played a pivotal role in the evolution of cultures, particularly when rapid cultural change is occurring due to foreign interventions or indigenous changes. Cultural turmoil activates the psyches of many individuals and sometimes creative cultural innovations emerge from this process (See John Perry, *Far Side of Madness*).

Mythologist Joseph Campbell in *The Mythic Image* has traced the process whereby new visions (often expressed in new myths) have guided human cultural evolution. First came early homo sapiens' fascination with fire, then with the animal world and the world of the planted seed. This was followed most recently by a far-reaching fascination with the planets and the stars. Campbell has argued that the pursuit of these realms in myth has directed human activity and enabled humans to surpass themselves.

> Neither reason, nor environmental contingencies have determined our collective and individual destinies, but as the poet Robinson Jeffers called them, 'visions that fool him out of his limits.' (Campbell *Myths to Live by* p. 249)

The psyche continues to generate myths that speak to present situations and issues, often speaking its myths through the voice of dreams. But another potent source of cultural and personal mythmaking is the psychotic mind.

In Perry's view, a visionary experience can be a renewal process in which components of the psychotic individual's make-up are undergoing change.. The psychosis can serve,

> as the psyche's own way of dissolving old states of being, and of creatively bringing to birth its new starts-its own way of forming visions of a renewed self and of a new design of life with revivified meanings in one's world. (John Perry, *Far Side of Madness* p. 11)

Associated Clinical Problems
When the psyche is activated to such an intense degree during visionary experiences, the individual can appear quite psychotic. Beliefs that meet the DSM-IV criteria for delusions, particularly grandiose ones, as well as hallucinations are usually present. At Diabysis, where people in visionary states were allowed to go through the full cycle of their visionary state, most resolved in 6-8 weeks without medication. For many, the experience became a turning point in their life toward growth. Yet during the acute phase, when psychotic symptoms are usually present, the individual can be seriously disabled and can benefit from residential treatment.

Treatment
Psychotic symptoms do indicate the need for special care. Judgment can be quite impaired and persons in the midst of visionary experiences can act recklessly and endanger themselves as well as others. Unlike other forms of spiritual emergence in which people are usually able to function in consensus reality, persons having visionary experiences can require round-the-clock surveillance. One of the main options needs to be considered to provide a safe container while the person is going through the experience. Several model residential programs have been developed including Kingsley Hall, Diabysis and Soteria, none of which, unfortunately, are open today.

In **Far Side of Madness**, John Perry, MD described his treatment of a 19-year-old male at Diabysis who presented with a number of grandiose delusions including that he was an "ace airman" and a second George Washington leading the defense of the country against the Russian communists who were trying to capture the world. At other times, he was Emperor of the Germans, Prince Valiant, and Christ. Yet Perry viewed these grandiose delusions as part of a positive transformative process in which the psyche is engaged in a mythic process.

Even though a psychiatrist, Perry did not prescribe any antipsychotic medication to squelch the psychotic symptoms. Rather than suppress or ignore the expression of the patient's psychotic experiences, Perry encouraged it since

> therapy should follow the psyche's own spontaneous movements. . .you work with what the psyche presents. (p. 136)

While the patient was in residential treatment at Diabysis, he met with Perry three times a week. In an early session, Perry had this patient draw, and a number of images of death emerged including being cremated, and being buried and clawing his way out of the grave. The whole psychotic renewal process took about 6 weeks, although the patient spent some additional time at the residential treatment center integrating the episode.

Case Examples
Expanded version of the "ace-airman" case described above

The Myths in Mental Illness case is an example of a visionary experience as well as a mystical experience.

Joshua Beil
Russell Shorto's account from GQ Magazine of the visionary experiences of Joshua Beil, a 23-year-old college graduate now working at a high tech firm in California. He went through a spiritual emergency that resulted in hospitalization and spent several months in recovery before he was able to return to college. Also included are his own reflections on this experience and the many parallels he found to the experiences of mystics and spiritual adepts throughout the ages.

WWW LIBRARY of Religion and Spirituality
The WWW LIBRARY of Religion and Spirituality contains interviews with John Perry, MD and articles on visionary experiences.

References
1 Wallace, A., Stress and rapid personality changes. International Record of Medicine, 1956. 169(12): p. 761-774.

REQUIRED QUIZ ITEM 19
Visionary Experiences

Visionary experiences can include psychotic symptoms.

True
False

Record your answer for later insertion into the Quiz.

REQUIRED QUIZ ITEM 20
Therapy with Visionary Experiences

John Perry, MD, developed a treatment program that

a) used high does neuroleptics to suppress psychotic symptoms quickly b) encouraged expression of the full range of psychotic experiences c) focused on the spiritual dimensions of the patient's experiences d) b and c

Record your answer for later insertion into the Quiz.