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# CULTURAL CONSIDERATIONS IN THE ASSESSMENT AND TREATMENT OF RELIGIOUS AND SPIRITUAL PROBLEMS

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## BACKGROUND

The religious and spiritual dimensions of life are among the most important cultural factors structuring human experience, beliefs, values, behavior, as well as illness patterns.<sup>33, 38</sup> Yet mainstream psychiatry, in its theory, research, and practice, as well as its diagnostic classification system, has tended to either ignore or pathologize the religious and spiritual issues that clients bring into treatment.<sup>49</sup>

This tendency, representing a form of cultural insensitivity, can be traced back to the roots of psychoanalysis as well as behaviorism and cognitive therapy. Freud saw religion as "a universal obsessional neurosis," Skinner largely ignored religious experience, and Ellis viewed religion as equivalent to irrational thinking and emotional disturbance. Similarly, spiritual experiences have been viewed as evidence of psychopathology. Freud<sup>19</sup> described the mystic perception of unity as a "regression to primary narcissism," and the 1976 report on mysticism by the Group for the Advancement of Psychiatry<sup>29</sup> viewed it as a projection of a "primitive infantile state." Even the limited references to religion and

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spirituality in DSM-III-R were used consistently to illustrate psychopathology.<sup>69</sup>

A number of recent studies indicate that psychiatry's negative view of religion and spirituality is not warranted.<sup>42</sup> A meta-analysis of religiosity and mental health found them to be positively related. Church affiliation and relationships with divine others (e.g., Christ, God, Virgin Mary, and so on) showed a significant positive association with several measures of well-being.<sup>66</sup> People reporting mystical experiences scored lower on psychopathology scales and higher on measures of psychological well-being than did controls.<sup>14, 32, 80</sup> And numerous studies also have documented the positive after-effects of the near-death experience.<sup>18, 24, 72</sup> Thus, for most people, religion and spirituality are more aptly viewed as sources of strength and well-being rather than as evidence of psychopathology.

One possible reason that religion and spirituality have been associated with psychopathology is the "religiosity gap" between mental health professionals and the general public. Surveys conducted in the United States consistently show that both the general public and psychiatric patients report that they attend church more frequently than do mental health professionals, believe in God at a significantly higher rate, and consider religion to be a much more important force in their lives.<sup>3, 39, 79</sup>

Psychiatry's insensitivity toward religious and spiritual issues is also apparent in the research literature, which has largely ignored religious variables.<sup>41</sup> Similarly, much of the recent clinical literature either has understated the incidence and significance of spiritual experiences or ignored studies that indicate their positive impact on mental health.<sup>49</sup> Yet studies have shown that mental health professionals frequently are called upon to assess and treat religious/spiritual issues. The Group for the Advancement of Psychiatry (GAP) reported that "manifest references to religion occur in about one third of all psychoanalytic sessions."<sup>28</sup> Members of the American Psychological Association reported that at least one in six of their clients presented issues that involve religion or spirituality.<sup>79</sup> In a recent survey, psychologists reported that 4.5% of their clients during the past 12 months brought a mystical experience into therapy.<sup>2</sup> This clearly challenges another GAP report that claimed that "mystical experiences are rarely observed in psychotherapeutic practice."<sup>29</sup> In addition, more than 70% of the world's population relies on nonallopathic systems of medicine, and the traditional healers who operate from these models often conceptualize and treat patients' complaints as having spiritual causes.<sup>53</sup>

Surveys of psychiatry and psychology training programs, however, indicate that both psychiatrists and psychologists are not given adequate training to deal with the religious and spiritual issues that frequently arise in clinical practice.<sup>78, 79</sup> Post<sup>68</sup> noted that "few psychiatrists are trained to understand religion, much less treat it sympathetically." Thus, when facing these issues, many psychiatrists may be operating outside

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the boundaries of their professional training, which raises both clinical and ethical concerns.

To redress the lack of sensitivity to the religious and spiritual problems that become the focus of psychiatric treatment, the authors of this article proposed a new diagnostic category, originally entitled "Psychoreligious or Psychospiritual Problem," to the Task Force on DSM-IV in December 1991. In January 1993, the Task Force approved the proposed category after changing the title to "Religious or Spiritual Problem" (V62.61) in order to conform to existing V Code categories (i.e., there is no "Psychomartial Problem" or "Psychoacademic Problem"). The definition in the DSM-IV reads:

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.<sup>6</sup>

For the first time in the DSM, there is an acknowledgment that religious and spiritual problems can be the focus of psychiatric consultation and treatment, and that many of these problems are not attributable to a mental disorder. It is hoped that this development will increase the accuracy of diagnostic assessments, reduce iatrogenic harm from misdiagnosis, and increase mental health professionals' respect for individual beliefs and values.

## RELIGION AND SPIRITUALITY

*Religion* and *spirituality* are sometimes used interchangeably. In other definitions, spirituality subsumes religion, and still others consider them to be mutually exclusive. Both religion and spirituality involve a sense of meaning and purpose in life, provide a source of love and relatedness, and help keep believers in relationship to the unknown and unknowable. A frequently drawn distinction in the literature, however, which we adhere to in this article, uses the term *religion* to refer to "adherence to the beliefs and practices of an organized church or religious institution."<sup>79</sup> *Spirituality* is used to describe "the transcendent relationship between the person and a Higher Being, a quality that goes beyond a specific religious affiliation."<sup>64</sup>

On virtually all measures, there has been a major decline in the strength of the mainstream religious institutions and confidence in religion and religious leadership in American culture.<sup>70</sup> A recent study of the religious behavior of Americans found that half of persons who tell pollsters that they attend church regularly are not telling the truth. Only 19% of adult Americans regularly practice their religion, whereas 7.5% describe themselves as agnostics, and 22.5% exhibit "only trace elements" of religion in their lives. Another 29% were rated as barely or

nominally religious, suggesting that half of Americans claim a religion that does not inform their attitudes or behavior.<sup>37</sup>

Yet, although some measures of participation in organized religion are decreasing, there has been a consistently or slightly increasing number of people who report that they believe in God or some spiritual force, who pray or engage in some spiritual practice, and who report a mystical experience.<sup>34, 49</sup> In the last 25 years, there seems to have been a widespread development of spiritual practices not associated with recognized religious institutions.<sup>7</sup> So this trend toward secularization "has not created an irreligious culture, only an unchurched one."<sup>84</sup> Accordingly, it seems possible that the incidence of spiritual problems seen in treatment is likely to increase in the future.

Religious problems have received much more attention than spiritual problems in the clinical and research literature. There is a handbook<sup>93</sup> and about a dozen journals devoted to pastoral counseling, several more to "Christian psychiatry," as well as professional organizations and conferences that address religious problems. Unfortunately, there is nothing comparable for spiritual problems. Jungian analysis, psychosynthesis, pastoral counseling, and the transpersonal psychology literature have addressed spiritual problems (see Lukoff et al<sup>52</sup> for a review of books, journals, and databases on spiritual problems). *The Journal of Transpersonal Psychology* has published several articles on spiritual problems,<sup>45, 51, 62</sup> but there is no journal dedicated to this topic.

Elements related to an organized religious tradition, however, and personal elements that are not in accord with the individual's religious tradition often appear together in an individual's experiences and problems.<sup>48</sup> For this reason, object-relations theorists have noted the importance of distinguishing between a person's idiosyncratic "God-representation," and the God as explicated in a particular denomination.<sup>17</sup> Thus, in many places in this article, the terms *religion* and *spirituality* are combined into a single term: *religious/spiritual*.

## ASSESSMENT OF RELIGIOUS AND SPIRITUAL PROBLEMS

Barnhouse<sup>8</sup> has pointed out that the pathologic significance of religious language seldom can be determined by the immediate content alone, especially if differential diagnosis with psychotic disorders is being considered. She suggests that a religious history be part of the standard evaluation. Spitzer et al,<sup>83</sup> Lovinger,<sup>44</sup> and Pruyser<sup>71</sup> also have discussed assessment methods for distinguishing religious/spiritual problems from psychopathology that presents with religious content. There are also a number of scales and interviews relevant to religious and spiritual problems.<sup>50, 51</sup> The DSM-IV specifically notes that clinicians assessing for schizophrenia in socioeconomic or cultural situations different from their own must take cultural differences into account:

Ideas that may appear to be delusional in one culture (e.g., sorcery and witchcraft) may be commonly held in another. In some cultures, visual or auditory hallucinations with a religious content may be a normal part of religious experience (e.g., seeing the Virgin Mary or hearing God's voice) (p 281).

Based on their experience working with an ultra-orthodox Jewish sect in Israel, Greenberg and Witzum<sup>23</sup> have proposed the following criteria to distinguish between normative strictly religious beliefs and experiences from psychotic symptoms. Psychotic episodes (1) are more intense than normative religious experiences in their religious community; (2) are often terrifying for the individual; (3) are often preoccupying and the individual can think of little else; (4) are associated with deterioration of social skills and personal hygiene; and (5) often involve special messages from religious figures. These criteria should be viewed as guidelines and applied in a culturally and contextually sensitive manner. Some genuine intense religious experiences can be awesome and frightening, preoccupy the individual for a time, and lead to temporary difficulties in functioning. Greenberg and Witzum remind clinicians: "Differentiating religious beliefs and rituals from delusions and compulsions is difficult for therapists ignorant of the basic tenets of that religion."<sup>23</sup>

The clinician's response to a person's religious/spiritual 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. Individuals undergoing powerful religious or spiritual experiences are sometimes at risk for being hospitalized as mentally ill.<sup>48</sup> A number of mental health professionals have discussed the importance of distinguishing intense spiritual experiences from psychosis.<sup>40, 48</sup> Criteria for making the differential diagnosis between psychopathology and authentic spiritual experiences have been proposed by Agosin,<sup>1</sup> Grof and Grof,<sup>27</sup> and Lukoff,<sup>45</sup> and there is considerable overlap among the proposed criteria. Lukoff suggested using good prognostic indicators to help distinguish between psychopathology and authentic spiritual experiences, including (1) good pre-episode functioning, (2) acute onset of symptoms during a period of 3 months or less, (3) stressful precipitants to the psychotic episode, and (4) a positive exploratory attitude toward the experience.

### **GUIDELINES FOR CULTURAL FORMULATION OF RELIGIOUS AND SPIRITUAL PROBLEMS**

The Task Force on DSM-IV worked closely with the Group on Culture and Diagnosis (sponsored by the National Institute of Mental Health [NIMH]) to achieve increased sensitivity to cultural issues. In addition to including sections addressing the specific cultural features related to many of the Axis I and II disorders, the Task Force worked

with the Group on Culture and Diagnosis to create a glossary of culture-bound syndromes in the manual's appendix and an outline for cultural formulation. Religion is only mentioned explicitly in the outline as a "cultural factor related to the psychosocial environment" that provides "emotional, instrumental and informational support." A more comprehensive view of the role of religion and spirituality would recognize the importance of these beliefs and practices in all aspects of the outline. For example, the "cultural identity of the individual" includes the person's religious/spiritual beliefs; one of the person's cultural reference groups can involve the person's religious/spiritual commitment or faith. "Cultural explanations of the individual's illness" are often influenced by a person's religious/spiritual identity, as is the "relationship between the individual and the clinician."

Numbers and Amundsen<sup>61</sup> have edited a book that describes for 20 Western Judeo-Christian denominations the nature of well-being, sexuality, dignity, mental illness, healing, caring, suffering, and death. Sullivan<sup>66</sup> continued this work for non-Western religions including Buddhism, Islam, Hinduism, Taoism, and Confucianism among others. Although not specifically focused on mental illness, these volumes provide an important contribution to understanding the world view of specific religious groups. Browning et al<sup>13</sup> have edited a third volume in the series focused on religion and psychiatry.

### **Types of Religious Problems**

In this section, a typology of religious problems is presented, followed by a section on spiritual problems, and cases in which such problems coexist with Axis I mental disorders. The most common examples of religious problems described in the clinical literature involve distress related to loss or questioning of faith; change in denominational membership or conversion to a new religion; intensification of adherence to the beliefs and practices of one's own faith; and joining, participating in, or leaving a new religious movement or cult. Usually such changes proceed without causing any significant psychological difficulty, but the clinical literature documents cases of individuals seeking mental health assessment and treatment for these problems.

#### *Loss or Questioning of Faith*

Barra et al<sup>9</sup> conducted a survey and reviewed the anthropologic, historical, and contemporary perspectives on religious loss as a grief-engendering phenomenon. They concluded that:

... a break in one's 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).

As this type of loss typically is not acknowledged by others, the authors described this phenomenon as "disenfranchised grief." They cite one case of a graduate student who described giving up believing in her organized religion of origin. She reported feeling alienated, fear, anxiety, anger, hopelessness, and even suicidal ideation, the common sequelae of a grief reaction. The American Psychiatric Association's "Guidelines Regarding Possible Conflict Between Psychiatrists' Religious Commitments and Psychiatric Practice"<sup>15</sup> mentions a case in which 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." Shafranske (Shafranske E: Beyond counter-transference: On being struck by faith, doubt, and emptiness, presented at the American Psychological Association Annual Meeting, 1991) 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.

A similar problem can be invoked when a person is ostracized by their religious community. 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."<sup>89</sup>

#### *Change in Denominational Membership or Conversion to a New Religion*

When persons from different religious backgrounds marry, one or both partners may experience feeling separated from their previous religious community. Geographic relocation sometimes lands a person in an area that does not have a branch of his or her original religious group. Powerful conversion experiences may result in a person switching to a new religious faith and group. These and related events can lead to a sense of loss and disconnection with a person's original religious beliefs and community.

#### *Intensification of Adherence to Beliefs and Practices*

Newly religious patients often experience conflicts between their former and current lifestyles, beliefs, and attitudes. For example, Spero<sup>81</sup>

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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 sullenness 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. Voluntary intensification of religious practice may be the result of a powerful religious experience. This can lead to problems when the person either does not feel free, or does not know how, to talk about the event. Intensification of religious practice is also a common coping mechanism used to deal with trauma, and is associated with the need to find meaning in the distressing event to avoid a breakdown of identity.<sup>87</sup>

### *New Religious Movements and Cults*

The topic of cults has been controversial. *Cults and New Religious Movements*<sup>4</sup> prepared by 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." In particular, psychiatrists were under pressure in the early 1980s, after the Jonestown massacre, to sanction the forcible "deprogramming and involuntary hospitalization of religious seekers who were turning East." In that same volume, Pattison provided a historical perspective on religious nonconformity and warned psychiatrists to resist labeling nonconformists as mentally ill.

There are some genuinely dangerous and destructive groups, however. A recent example is the Branch Davidians under the leadership of David Koresh. Welwood<sup>92</sup> has discussed the characteristics of "spiritual group pathology" that distinguish "between false prophets and genuine spiritual masters, between misguided cults and wholesome spiritual communities":

1. Cult leaders have total power to validate or negate the self-worth of the devotees and use this power extensively;
2. Cults are held together by allegiance to a cause, a mission, and ideology;
3. Cult leaders keep their followers in line by manipulating emotions of hope and fear;
4. "Group think" is used to knit followers together; and
5. Cult leaders are often self-styled prophets who have not studied with great teachers or undergone lengthy training or discipline.

More than 90% of persons who join new religious groups leave within 2 years.<sup>43</sup> Post<sup>67</sup> points out that "if brainwashing goes on, it is extremely ineffective." For the vast majority, such "radical religious departures" are part of their adolescent or young adult identity exploration. Vaughan<sup>88</sup> also points out that many individuals who have left destructive groups reported that the experience contributed to their wisdom and maturity through an empowering sense of having met the

challenge by restoring their integrity. 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. Often students transitioning from the "culture of embeddedness" with their spiritual teachers to more independent functioning seek psychotherapeutic help.<sup>11</sup> In therapy with someone who has left, or who is considering joining or leaving a spiritual group, the following questions could be pursued:

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 running away from my life as it is? (p 275).<sup>88</sup>

### **Types of Spiritual Problems**

The definition of spiritual problems in the DSM-IV includes the "questioning of other spiritual values which may not necessarily be related to an organized church or religious institution." Questioning of spiritual values implies that the person lacks direction, certainty, and confidence in his or her "involvement or state of awareness or devotion to a higher being or life philosophy."<sup>90</sup> The most common spiritual problems involve distress related to a mystical experience, a near-death experience, a spiritual emergence/emergency, meditation, and medical/terminal illness.

#### *Mystical Experience*

Definitions used by researchers and clinicians vary considerably, ranging from Neumann's "upheaval of the total personality"<sup>58</sup> to Greeley's "spiritual force that seems to lift you out of yourself."<sup>22</sup> A definition of mystical experience both congruent with the major theoretical literature and clinically applicable characterizes it as a transient, extraordinary experience marked by feelings of unity, harmonious relationship to the divine and everything in existence, as well as euphoric feelings, noesis, loss of ego functioning, alterations in time and space perception, and the sense of lacking control over the event.<sup>2, 31</sup> Numerous studies indicate that 30% to 40% of the population have had mystical experiences,<sup>82</sup> suggesting that they are normal rather than pathologic phenomena.

A case example illustrates how a mystical experience can become

the focus of treatment. The patient was a woman in her early 30s who sought therapy to deal with unresolved parental struggles and guilt over a younger brother's psychosis. Approximately 2 years into her therapy, she underwent a typical mystical experience, including a state of ecstasy, a sense of union with the universe, a heightened awareness transcending space and time, and a greater sense of meaning and purpose to her life. This experience increasingly became the focus of her continued treatment, as she worked to integrate the insights and attitudinal changes that followed. Because of the rapid alteration in her mood and her unusual ideation, the authors considered diagnoses of mania, schizophrenia, and hysteria. But they rejected them because many aspects of her functioning were either unchanged or improved, and overall her experience seemed to be "more integrating than disintegrating." They concluded that "while a psychiatric diagnosis cannot be dismissed, her experience was certainly akin to those described by great religious mystics who have found a new life through them."<sup>29</sup> Nobel<sup>59</sup> noted that although mystical experience may result in greater psychological health, the process is sometimes disruptive and may prompt individuals to seek treatment.

### *Near-death Experience*

Considerable scientific research during the past decade has established that near-death experience (NDE) is a clearly identifiable psychological phenomenon not attributable to a mental disorder.<sup>10</sup> It is a profound subjective event experienced by persons who come close to death (or who are believed dead and unexpectedly recover) as a result of serious injury or illness, or who confront a potentially fatal situation and escape uninjured.<sup>85</sup> Phenomenologically, NDE includes (1) a characteristic temporal sequence of states (i.e., peace and contentment, detachment from physical body, entering a transitional region of darkness, seeing a brilliant light, and passing through the light into another realm of existence); as well as (2) a cluster of subjective components (i.e., strong positive effect, dissociation from the physical body, and transcendental or mystical elements).<sup>73</sup>

About one third of all individuals who have had a close encounter with death have had NDEs.<sup>76</sup> In 1982, Gallup<sup>20</sup> estimated that approximately 8 million American adults have had NDEs. Numerous studies of the aftereffects of NDE provide strong evidence of its nonpathologic nature. Difficulties frequently arise, however, in the wake of a NDE. Specific *intrapsychic* problems include (1) ongoing anger or depression related to losing the near-death state; (2) difficulty reconciling the NDE with previous religious beliefs, values, or lifestyle; and (3) the fear that the NDE might indicate mental instability. *Interpersonal* problems brought about by the NDE include (1) difficulty reconciling attitudinal changes with the expectations of family and friends, (2) a sense of isolation, (3) a fear of ridicule or rejection from others, (4) difficulty communicating the meaning and impact of the NDE, and (5) difficulty

maintaining previous life roles that no longer carry the same significance.<sup>25</sup>

Many individuals have reported doubting their mental stability, and therefore not discussing the NDE with friends or professionals for fear of being rejected, ridiculed, or regarded as psychotic or hysterical. For example, one person reported, "I've lived with this thing [NDE] for 3 years and I haven't told anyone because I don't want them to put the straight jacket on me."<sup>77</sup> A hospitalized 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." Despite such problems, the overwhelming majority of individuals having a NDE consistently report favorable aftereffects including positive attitude and value changes, personality transformation, and spiritual development.<sup>73</sup>

### *Spiritual Emergence/Emergency*

Grof and Grof<sup>27</sup> have collected case reports illustrating the more common presentations often relating to the intensive practice of Asian spiritual techniques that entered the West starting in the 1960s. These include mystical experiences, kundalini awakening (a complex psychospiritual transformative process described in the Yogi tradition), shamanistic initiatory crisis (a rite of passage for shamans-to-be in indigenous cultures, commonly involving physical illness and/or psychological crisis), and psychic opening (the sudden occurrence of paranormal experiences). Grof and Grof reported that whereas in spiritual emergency there is an uncontrolled occurrence of spiritual phenomena with significant disruption in psychological/social/occupational functioning, in *spiritual emergence* there is a gradual unfolding of spiritual potential with minimal disruption in psychological/social/occupational functioning.

Non-Western traditional cultures distinguish between serious mental illness and the spiritual emergencies experienced by some shamans-to-be.<sup>60</sup> Anthropologic accounts show that babbling confused words, displaying curious eating habits, singing continuously, dancing wildly, and being "tormented by spirits" are common elements in initiatory crises that signify an individual's destiny to become a shaman.<sup>35</sup> Individuals in Western cultures occasionally may experience similar spiritual problems.<sup>47, 48</sup>

Thus many spiritual emergencies are conceptually comparable to the DSM-IV category of bereavement. 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. Rather, the diagnosis of bereavement, which is in the same section as religious or spiritual problem, is assigned. Similarly, spiritual emergencies that can result in long-term improvement in overall well-being and functioning, when treated properly, should not be diagnosed as mental disorders but rather as a religious or spiritual problem.

### *Meditation*

Altered perceptions have been reported during initial phases of intensive meditation, but spiritual teachers do not consider them pathologic.<sup>91</sup> The DSM-IV also acknowledges that "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"<sup>6</sup> (p 488). Such experiences, if distressing, should be categorized under religious or spiritual problem.

Kornfield<sup>36</sup> described a spiritual emergency that took place at an intensive meditation retreat. The "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 said, 'When I look at each of you, I see behind you a whole trail of bodies showing your past lives.' " The meditation community handled the situation by stopping his meditation practice and starting him jogging, 10 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 3 days, he was able to sleep again and was allowed to start meditating again, slowly and carefully. Asian traditions recognize a number of pitfalls associated with intensive meditation such as "false enlightenment," associated with delightful or terrifying visions, especially of light. When these spiritual traditions are transplanted into Western contexts, such problems still occur.<sup>27</sup>

Meditation, especially Buddhist forms, however, may have a special attraction for persons with borderline and narcissistic personality disorders because the doctrine legitimates and rationalizes their lack of self-structure and integration.<sup>16</sup> Walsh and Roche<sup>91</sup> discussed how individuals at risk for more serious psychological disturbance during meditation practice can be identified. Although such difficulties occur in meditation practice, the clinical and research literature also documents a wide range of benefits.<sup>57</sup>

### *Medical/Terminal Illness*

Although listed here as a spiritual problem, both religious and spiritual beliefs and practices often influence the ways patients react to medical illness.<sup>38</sup> The religious aspects of patients' lives, however, often are ignored or only superficially explored by consultation-liaison psychiatrists. Waldfoegel and Wolpe<sup>89</sup> describe the case of a woman hospitalized with a spinal injury following an automobile accident who showed symptoms consistent with a depressive disorder. But the consulting psychiatrist found that she missed the religious and spiritual practices that were part of her life before the hospitalization. He recommended

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Meditation, especially Buddhist forms, however, may have a special attraction for persons with borderline and narcissistic personality disorders because the doctrine legitimates and rationalizes their lack of self-structure and integration.<sup>16</sup> Walsh and Roche<sup>91</sup> discussed how individuals at risk for more serious psychological disturbance during meditation practice can be identified. Although such difficulties occur in meditation practice, the clinical and research literature also documents a wide range of benefits.<sup>57</sup>

### *Medical/Terminal Illness*

Although listed here as a spiritual problem, both religious and spiritual beliefs and practices often influence the ways patients react to medical illness.<sup>38</sup> The religious aspects of patients' lives, however, often are ignored or only superficially explored by consultation-liaison psychiatrists. Waldfogel and Wolpe<sup>89</sup> describe the case of a woman hospitalized with a spinal injury following an automobile accident who showed symptoms consistent with a depressive disorder. But the consulting psychiatrist found that she missed the religious and spiritual practices that were part of her life before the hospitalization. He recommended

psychotherapy to explore her religious beliefs in light of her accident, and that she obtain a tape player so that she could listen to religious music. A clergy member of her faith was contacted and made several hospital visits to provide support.

In particular, terminal illnesses raise fears of physical pain, the unknown risk of dying, the threat to integrity, and the uncertainty of life after death. Several articles have highlighted the value of consultation-liaison psychiatrists, doctors, and nurses working together with clergy in caring for dying patients.<sup>15, 75</sup> Hay<sup>30</sup> noted that, "Because terminal illness may precipitate a spiritual crisis, all hospice team professionals bear some responsibility for making a spiritual assessment and directing interventions."

### **Religious/Spiritual Problem Coexisting with Mental Disorder**

The DSM-IV includes a number of important changes in the conceptualization of the section containing V Codes. In DSM-III-R, these diagnoses were called "Conditions Not Attributable to a Mental Disorder." In DSM-IV, the section for these problems is entitled "Other Conditions That May Be A Focus of Clinical Attention." In addition to recognizing that a problem can occur without a mental disorder, and that a problem can exist with an unrelated concomitant mental disorder, the new definition of this section specifically notes the possibility that an individual can have a mental disorder that *is related* to the problem, as long as the problem is sufficiently severe to warrant independent clinical attention. Thus, for example, religious or spiritual problem could be assigned *along with* bipolar disorder if the religious/spiritual content is addressed in the treatment of a manic episode. This greatly expands the potential usage of this category as the symptoms and treatment of some mental disorders include religious and spiritual aspects.<sup>74</sup> Some examples of common co-occurrences are presented in the following sections.

#### *Alcohol and Drug Dependence and Abuse*

The strong relationship between religious/spiritual commitment (e.g., church attendance) and the avoidance of alcohol and illicit drugs is well established. It is also known that patients in alcohol treatment who become involved with a religious community after treatment have lower recidivism rates than those who do not.<sup>42</sup> Unfortunately, not much is known about the religious/spiritual dimensions of addiction treatment because religious/spiritual variables have been neglected in research.<sup>55</sup> Yet Twelve Step Programs in which religion/spirituality plays a central role dominate addiction treatment in mental health settings. Examples include the following: One of the 12 steps from Alcoholics Anonymous (AA) mentions "A Power greater than ourselves," the final step mentions a "spiritual awakening," and five of the

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12 steps make a specific reference to God. The founders of AA did not ponder whether religious and spiritual factors are important in recovery, but rather if it is possible for alcoholics to recover without the help of a higher power. Some theorists and clinicians have even approached addictions as essentially spiritual crises, not mental disorders.<sup>26</sup>

### *Obsessive-Compulsive Disorder*

Superficially, religious rituals and obsessive-compulsive behaviors share some common features: the prominent role of cleanliness and purity, the need for rituals to be carried out in specific ways and number of times, and the fear of performing the ritual incorrectly. Greenberg and Witzum<sup>23</sup> describe an individual whose concern with correctly saying his prayers led him to spend 9 hours a day in prayer instead of the usual 40 to 90 minutes spent by other ultra-orthodox Jews. Persons with obsessive-compulsive disorder in this religious community became so preoccupied with some detail or area of religious practice that they ignored or violated other tenets of their faith. In these individuals, scrupulous devoutness involved the use of religion as a metaphor for the expression of compulsive requirements. (The authors also concluded, however, that ultra-orthodox Jews were not at a higher risk for developing obsessive-compulsive disorder.)

In such cases, Greenberg and Witzum recommend meeting together with the patient's religious leader present and that, "During assessment, the terms and symbols of the religion of strictly religious patients should be used . . . [to] enable the patient to feel as comfortable as possible." When these religious factors warrant independent clinical attention and are addressed explicitly in treatment, religious or spiritual problem should be coded along with obsessive-compulsive disorder.

### *Psychotic Disorders*

Co-occurrence of a mental disorder and a religious or spiritual problem occurs among the psychotic disorders, especially manic psychosis. Goodwin and Jamison<sup>21</sup> speculate that, "There may have been many mystics who may well have suffered from manic-depressive illness—for example, St. Theresa, St. Francis, St. John." Podvoll<sup>65</sup> and Lukoff<sup>46</sup> also have discussed the similarities between manic psychotic episodes and mystical experiences.

Some individuals with schizophrenia present with delusions of being Christ or receiving direct communication from God. Even in these cases, the treatment literature documents that there is often therapeutic value in addressing a person's religious ideation to salvage the valid religious/spiritual dimensions of their experience.<sup>12</sup> For example, when the patient developed the grandiose delusion that he or she was God or the messiah, the valid religious/spiritual dimensions of the experience can be affirmed through psychotherapy. Transpersonal psychotherapy can be especially valuable in the postpsychotic period because it pro-

notes the integration of the healthy parts of religious/spiritual experiences in psychosis.<sup>48</sup>

## SUMMARY

Scott Peck, a psychiatrist who has written several books on the spiritual dimensions of life, including the best-selling *The Road Less Traveled*, gave an invited address which drew a standing-room only audience at the 1992 Annual Meeting of the American Psychiatric Association. He pronounced that psychiatrists are "ill-equipped" to deal with either religious/spiritual pathology or health. Continuing to neglect religious/spiritual issues, he claimed, would perpetuate the predicaments that are related to psychiatry's traditional neglect of these issues: "occasional, devastating misdiagnosis; not infrequent mistreatment; an increasingly poor reputation; inadequate research and theory; and a limitation of psychiatrists' own personal development."<sup>63</sup>

In recent years, there have been a number of developments that have begun to redress psychiatry's cultural insensitivity to the religious and spiritual dimensions of life. In 1990, the APA Committee on Religion and Psychiatry initiated an APA Position Statement entitled "Guidelines Regarding Possible Conflict Between Psychiatrists' Religious Commitments and Psychiatric Practice."<sup>5</sup> These guidelines emphasized that "psychiatrists should maintain respect for their patient's beliefs . . . and not impose their own religious, antireligious, or ideologic systems of beliefs on their patients, nor should they substitute such beliefs or ritual for accepted diagnostic concepts or therapeutic practice." These guidelines reinforce the importance of acknowledging and respecting differences in religious/spiritual beliefs between clinicians and their patients. More recently, the Accreditation Council for Graduate Medical Education published the new "Special Requirements for Residency Training in Psychiatry," which incorporated several changes mandating instruction about gender, ethnicity, sexual orientation, and religious/spiritual beliefs. Finally, the inclusion of "religious or spiritual problem" as a diagnostic category for the first time in the DSM-IV acknowledges that religious and spiritual issues can be the focus of psychiatric consultation and treatment. John McIntyre, MD, former APA President, and Harold Pincus, Director of the APA's Office of Research, observed that this new entry in DSM-IV was "a sign of the profession's growing sensitivity not only to religion but to cultural diversity generally."<sup>54</sup> It is hoped that these developments will increase the accuracy of diagnostic assessments, reduce iatrogenic harm from misdiagnosis, and increase the mental health professional's respect for individual beliefs and values.

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