

Religious or Spiritual Problem

A Culturally Sensitive Diagnostic Category in the DSM-IV

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A new diagnostic category entitled religious or spiritual problem has been included in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) under Other Conditions That May Be a Focus of Clinical Attention. Along with several other changes, this category contributes significantly to the greater cultural sensitivity incorporated into DSM-IV. The authors review the approval process, including the changes that were made in both the proposed new category and the former V Code section of DSM-III-R. In addition, the definition, assessment methods, types, and clinical significance of religious and spiritual problems are clarified, along with the differential diagnostic issues raised by the definitional changes in the former V Code section. Finally, clinical issues involving cultural sensitivity and the implications for future research are addressed. The new category could help to promote a new relationship between psychiatry and the fields of religion and spirituality that will benefit both mental health professionals and those who seek their assistance.

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Before the publication of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), arguments were made for a more culturally sensitive diagnostic classification system (Fabrega, 1987, 1992; Kirmayer, 1991; Kleinman, 1988; Mezzich et al., 1992). Brody (1990, 1994) highlighted how psychiatry's emphasis on the biological aspects of behavior has ignored essential knowledge about the cultural basis of a person's behavior and interaction with the environment. Mezzich et al. (1992) addressed the need for a systematic consideration of cultural issues in developing a classification system that could be sensitive to the increasing ethnic diversity of the patient population.

Encouragingly, the DSM-IV reflects significant progress toward redressing psychiatry's prior cultural insensitivity. One important step involved the DSM-IV Task Force's approval of a new diagnostic category entitled religious or spiritual problem. This new category was proposed by Lukoff, Lu, and Turner (1992) to offset the tendency of mental health professionals to ignore or pathologize religious and spiritual issues brought into treatment. In a previous article, the authors reviewed this tendency and argued that the religious and spiritual dimensions of culture are among the most important factors that structure human experience, beliefs, values, behavior, and illness patterns.

In this article, the authors will review: a) the approval process, including the changes that were made in both the new category and the former V Code section of DSM-III-R; b) the definition, assessment methods, types, and clinical significance of religious and spiritual problems; c) the differential diagnostic issues; d) clinical issues involving cultural sensitivity; e) the implications of the new diagnostic category for future research; and f) the potential long-term impact of the new category on the mental health professions.

New Diagnostic Category

The need for a category involving religious and spiritual problems was raised in both psychiatric and transpersonal psychology literature addressing iatrogenic harm from misdiagnosis of religious and spiritual issues (Bowers, 1974; Lukoff, 1985). In January 1991, the authors of the category conducted a systematic literature review that elicited approximately 300 journal articles, chapters, and books, including about 50 empirical and clinical studies of specific religious or spiritual problems. In addition, they networked with the American Psychiatric Association Committee on Religion and Psychiatry, the Workgroup on Culture and Diagnosis, and many experts in the field. The new category, originally entitled psychoreligious or psychospiritual problem, was submitted to the DSM-IV Task Force in December 1991. It addressed problems of a religious or spiritual nature that are the focus of clinical attention and not attributable to a mental disorder. As the proposal was reviewed by the Multiaxial Issues Work Group and the DSM-IV Task Force, arguments were

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made for subsuming it under existing axis I (*i.e.*, adjustment disorder) and V Code (*i.e.*, phase of life problem; identity problem) categories. In written responses, the authors pointed out a number of counterarguments. Foremost is that when religious or spiritual problems are triggered by an extremely stressful event, such as a near-death experience, they would be comparable to the DSM-III-R V Code category of uncomplicated bereavement. Just as the diagnosis of a major depressive episode would not be given when someone's response to a death meets diagnostic criteria yet results from "a normal reaction to the death of a loved one," so the characteristic sequelae of a near-death experience should not be viewed as evidence of a mental disorder. Rather they would be considered normal and expectable reactions to a life-threatening stressor. Another argument highlighted that one of the intended functions of the new category was to anchor the nonpathological end of the differential diagnostic spectrum regarding religious or spiritual problems. Subsuming it under an existing axis I disorder would not achieve such an anchor, thereby perpetuating the current lack of clarity in differential diagnosis. Finally, the authors argued that using the existing DSM-III-R categories would not guide the clinician toward the relevant diagnostic or treatment literature involving religious and spiritual problems.

In January 1993, the Task Force approved the proposed category after changing the title from psychoreligious or psychospiritual problem to religious or spiritual problem in order to conform to existing V Code categories (*i.e.*, there is no psychomartial problem or psychoacademic problem). In addition, the Task Force changed the definition as follows:

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 [APA], 1994).

This revised definition removed not only two of the four examples of religious problems listed in the proposed definition (*i.e.*, change in denominational membership and intensification of adherence to religious practices and orthodoxy), but also the two examples of spiritual problems. Mystical and near-death experiences were replaced by a less specific "questioning of other spiritual values which may not necessarily be related to an organized church or religious institution." The authors unsuccessfully rebutted this change, arguing that it reduced the clarity of the new category by not identifying

specific examples well documented in the literature and opting for a vague and less current phrase, "questioning of spiritual values."

New Diagnostic Section

In addition to the above-noted changes, the Task Force also made two significant changes in the V Code section of DSM-III-R. First, the name V Code, which was originally to be changed to Z Code to be in line with the ICD-10 nomenclature, was finally renamed Other Conditions That May Be a Focus of Clinical Attention. The second change involved a new definition of these other conditions which introduced a third possible relationship with a mental disorder that was not included in DSM-III-R. In addition to the possibilities of either a problem without a mental disorder or a problem with an unrelated concomitant mental disorder, the new definition includes the following possibility:

The individual has a mental disorder that is related to the problem, but the problem is sufficiently severe to warrant independent clinical attention (*e.g.*, partner relational problem that is sufficiently problematic to be a focus of treatment that is also associated with major depressive disorder in one of the partners, in which case both can be coded) (APA, 1994).

This third possibility introduces the differential diagnostic challenge of assessing possible overlap between a mental disorder and any of the Other Conditions. This definitional change both acknowledges a previously unaddressed clinical reality and necessitates further differential diagnostic guidelines and criteria.

Definitions of Religion and Spirituality

Attempts within the clinical literature to address religious and spiritual concerns raise a number of definitional issues. Both religion and spirituality involve a sense of meaning and purpose in life, provide a source of love and relatedness, and intend to keep believers in right relationship to the unknown and unknowable. While these terms are sometimes used interchangeably (*e.g.*, Webster's II New Revised Dictionary defines spiritual as "of, or relating to, religion or religious matters"), in other definitions spirituality subsumes religion. For example, Miller (1990, p. 261) states that spirituality involves "transcendental processes that supersede ordinary material existence. This includes but is not limited to systems of religion." Still others consider them to be mutually exclusive. While there is no consensus as to the existence and/or nature of boundaries between religion and spirituality, a frequently drawn distinction in the literature, which we adhered to in our proposal, utilizes the term religion to refer to "adherence to the beliefs and practices of an organized

church or religious institution" (Shafranske and Maloney, 1990, p. 72). Spirituality is used to describe "the transcendent relationship between the person and a Higher Being, a quality that goes beyond a specific religious affiliation" (Peterson and Nelson, 1987).

These definitions closely parallel the definitions of religion and spirituality offered in the *Thesaurus of Psychological Index Terms* (Walker, 1991). Other definitions from the field of transpersonal psychology (Vaughan, 1991) describe spirituality as a universal experience that is present within the full spectrum of human existence.

Whereas spirituality is essentially a subjective experience of the sacred, religion involves subscribing to a set of beliefs or doctrines that are institutionalized (p. 105) As an innate capacity that exists in every human being, psychologically healthy spirituality is not limited to any one set of doctrines or practices. From a psychological perspective, spirituality is a universal experience, not a universal theology (p. 116).

Historically, spirituality was not widely distinguished from religion until the rise of secularism during this century. Many people became disillusioned with religious institutions, often seeing them as preventing rather than facilitating a personal experience of the transcendent. In the last 25 years, this split between religion and spirituality has led to the widespread development of spiritual practices not associated with recognized religious institutions. Accordingly, on virtually all measures, there has been a major decline in the strength of the mainstream religious institutions that have predominated in American culture (Princeton Religious Research Center, 1993). Yet, while confidence in religion and religious leadership is decreasing, there has been a consistent 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 religious or mystical experience (Jones, 1993; Lukoff et al., 1992). So this trend toward secularization "has not created an irreligious culture, only an unchurched one" (Stark and Bainbridge, 1985, p. 441). Accordingly, it seems possible that the incidence of spiritual problems seen in treatment is likely to increase in the future.

Assessment of Religious/Spiritual Problems

Surveys of the directors of psychiatric residency and psychology internship programs show that training in the assessment of religious and spiritual problems is not typically covered (Sansone et al., 1990; Shafranske and Maloney, 1990). These findings combined with other studies suggest that this area is not usually addressed in psychiatric evaluations (Lukoff et al., 1992).

Nevertheless, interviews and assessment protocols have been developed and published for several clinical situations which psychiatrists face. These are distinct from pastoral counseling assessment protocols which generate pastoral diagnoses that "are seen as being necessarily followed by 'Pastoral Treatment'" (Draper and Steadman, 1993, p. 118). These interviews and assessment protocols are described below.

Differentiating Between Psychopathology and Religious/Spiritual Problems

Gabbard et al. (1982) have highlighted the need for psychiatrists to respect and differentiate unusual but integrating experiences from those that are distressing and disorganizing. The clinician's initial assessment of powerful spiritual experiences can significantly influence the eventual outcome. As Greyson and Harris (1987) 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. Luke (1985) has noted that individuals undergoing powerful religious or spiritual experiences are sometimes at risk for being hospitalized as mentally ill.

Barnhouse (1986) has pointed out that the pathological significance of religious language can seldom 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. (1980), Lovinger (1984), and Pruyser (1984) have also discussed assessment methods for distinguishing religious/spiritual problems from psychopathology that presents with religious content. Even in cases where individuals with psychotic disorders present with delusions of being Christ or receiving direct communication from God, the literature documents there is often therapeutic value in addressing the person's religious/spiritual ideation (Bradford, 1985; Hoffman et al., 1990).

Greenberg and Witzum (1991) proposed several criteria for distinguishing normative strictly religious beliefs and experiences from psychotic symptoms, based upon work with an ultra-orthodox Jewish sect in Israel. They argued that psychotic episodes are a) more intense than normative religious experiences, b) often terrifying and preoccupying for the individual, c) associated with deterioration in social/self-care functioning, and d) often involve special messages from religious figures.

Criteria for differentiating intense spiritual experiences from psychopathology have been proposed by

Agosin (1992), Grof and Grof (1990), and Lukoff (1985), with considerable overlap. To help with the differentiation, Lukoff (1985) suggested using good prognostic indicators, including a) good pre-episode functioning, b) acute onset of symptoms (3 months or less), c) stressful precipitants, and d) a positive exploratory attitude toward the experience.

Consultation-Liaison Psychiatry

Recently Waldfogel and Wolpe (1993) pointed out that "religion plays an important role in the lives of most Americans and often influences the ways patients react to medical illness. However, the religious aspects of patients' lives are often ignored or only superficially explored by consultation-liaison psychiatrists" (p. 473). They propose a six-part typology of religious issues that are important to assess, illustrating with case vignettes how each of these areas can profoundly influence treatment. Stoll (1979) and Braverman (1987) have also discussed religious/spiritual consultation-liaison assessment issues.

Treatment of Terminally Ill Patients

Hay (1989) pointed out that "Because terminal illness may precipitate a spiritual crisis, all hospice team professionals bear some responsibility for making a spiritual assessment and directing interventions" (p. 25). He published a spiritual assessment instrument for use with terminally ill patients that specifically addresses suffering and unresolved religious/spiritual issues.

Religious/Spiritual Problems of Hospitalized Psychiatric Patients

Kroll and Sheehan (1989) found that hospitalized psychiatric patients are as religious as the general population, and they suggest that patients may turn more to religion during such crises. At St. Elizabeth's Hospital in Washington, D.C., the Chaplain Program, headed by Clark Aist, conducts a "spiritual needs assessment" on each inpatient, concluding with a treatment plan that identifies religious/spiritual needs and problems, role of pastoral intervention, and recommended religious/spiritual activities. Similarly, the psychiatric nursing profession has demonstrated greater awareness and likelihood of assessing the spiritual problems of hospitalized patients (Boutell and Bozett, 1990; Carpenito, 1983).

Types of Religious Problems

The most common examples of religious problems include change in denominational membership or conversion to a new religion, intensification of adherence to the beliefs and practices of one's own faith, and a loss or questioning of faith. Usually such changes pro-

ceed without causing any significant psychological difficulty, but the clinical literature documents cases of individuals seeking mental health assessment and treatment for these problems (Lukoff et al., 1992).

Change in Denominational Membership or Conversion to a New Religion

This may result when persons from differing religious backgrounds marry. In some cases, the change may therefore be experienced as forced rather than voluntary. It may then lead to a sense of loss associated with separation from a previously valued religious community. If a person has moved to a community that does not have a branch of the original religious group, a similar serious loss may be experienced.

A recent review article examines the literature about conversion theories, including understanding it as individual active meaning-making (Thumma, 1991). Since a sense of meaninglessness is an important symptom for many depressed patients, this may be particularly relevant for psychiatrists. Conversion may also offer relief from "the tyranny of narcissism" by helping a person realize that he/she is not the center of the world but rather a part of a larger whole (Capps, 1990). Rambo (1993) reviews various theories of conversion, examines the role of cultural and social factors in the conversion process, and describes how different religions and disciplines view conversion.

Intensification of Adherence to Beliefs and Practices

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, and may take on the general character of conversion. 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 (van der Lans, 1991, pp. 313-322).

Loss or Questioning of Faith

This is another common religious problem, likely to be particularly difficult for those who are at the earlier stages of faith development. Fowler (1981), 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. Certain transitions are more likely than others to be experienced as psychologically difficult.

This problem can also arise when individuals are

ostracized from their religious community. For example, 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 hospitalization" (Waldfoegel and Wolpe, 1993).

Guilt

Psychiatry has excellent ways of dealing with neurotic guilt, but is less effective in dealing with guilt that results from an actual offense a patient has committed. If such real guilt is not dealt with appropriately, it can cause or aggravate a serious mental disorder, including psychosis. One of the authors (R. T. B.) treated a woman hospitalized with a psychotic depression, who refused to dress, bathe, or eat. She would not talk, except to say that she needed a priest, that she had something to confess. This request was dismissed by the staff as delusional. But when there was no change after 2 months, a priest was finally called. After hearing her confession, he told the physician that she did indeed have something to confess, but of course did not reveal what that was. She was fully recovered and discharged from hospital within 2 weeks. Since, as this case illustrates, religion has techniques for dealing with real guilt, when patients continue to be troubled by such feelings, referral to clergy for help with this aspect of the problem should be seriously considered (Barnhouse, 1985, pp. 57-84; Todd, 1985).

Cults

Cult membership constitutes a special case of conversion to a new religion. Many consider cults to be uniformly oppressive. This view overlooks the fact that all religions originally began as cults, and however mainstream they may have eventually become, they were originally perceived as a threat to established customs and values. It is widely believed that cult membership is detrimental to mental health, but in a comprehensive review of the recent literature, Rochford et al. (1989, pp. 57-78) demonstrate that this generalization is doubtful. They also perceive psychiatrists engaged in deprogramming as agents of social control, finding this role questionable. The APA's volume on cults considers them from several points of view, including sociological and legal (Galanter, 1989). The 16 chapters vary in their attitude toward cults, as well as in their view of the psychiatrist's role in dealing with the problems which cult membership may raise, either for members or for their families. The beliefs and practices of cults vary widely, and there is good evidence that some of them are helpful to their adherents (Rochford, 1985). Nevertheless, some genuinely dangerous and destruc-

tive groups do arise under the banner of religion, and can lead to serious psychological difficulties in those unfortunate enough to belong to them. The most recent example is the Branch Davidians under the leadership of David Koresh.

Types of Spiritual Problems

The only guidelines for spiritual problems provided by the Task Force's revised definition was the "questioning of other spiritual values which may not necessarily be related to an organized church or religious institution." According to the *Psychiatric Dictionary* (Campbell, 1989), value is defined as "[t]hat which is esteemed, prized, or deemed worthwhile by a person or a culture Values concern preferences for 'life goals' and 'ways of life.'" Therefore, questioning of spiritual values implies that the person lacks direction, certainty, and confidence in his/her "involvement or state of awareness or devotion to a higher being or life philosophy" (definition of spirituality in the *Thesaurus of Psychological Index Terms* [Walker, 1991]). For some individuals, this may involve questioning their whole way of life, purpose for living, and source of meaning. In addition, their social world can be affected, since spirituality is frequently the source of "the deepest sense of belonging and participation" (Remen, 1993). It has also been noted that "[v]alues are experientially determined; they are not innate" (Campbell, 1989). Although the role that biological and environmental factors have in determining values is controversial, it is apparent that values are greatly influenced by culture.

Although the revised definition does bring attention to problems that can arise when one's spiritual values are questioned, it fails to acknowledge the specific types of spiritual problems documented in the literature. Most prominent among these are the mystical experience and near-death experience.

Mystical Experience

In a previous article (Lukoff et al., 1992), the authors reviewed the definition of mystical experience and the numerous studies assessing the incidence in both the general and clinical population. The treatment literature has addressed the problems of integration that can follow a mystical experience (Group for the Advancement of Psychiatry, 1976, p. 806; Nobel, 1987).

Near-Death Experience

Scientific research over the past decade has established the near-death experience (NDE) as an identifiable psychological phenomenon not attributable to a mental disorder (Basford, 1990). The authors also reviewed the definition, phenomenology, and incidence

of NDE in a previous article (Lukoff et al., 1992). Several clinicians have focused on the significant intrapsychic and interpersonal difficulties that frequently arise in the wake of an NDE, such as anger, depression, and isolation (Greyson and Harris, 1987). Significantly, in spite of such problems, individuals experiencing an NDE consistently report positive aftereffects, including positive attitude and value changes, personality transformation, and spiritual development.

Spiritual Emergence/Emergency

Within the field of transpersonal psychology, a range of clinical phenomena has also been conceptualized as a spiritual problem. Since the influx of Eastern spiritual practices and the rising popularity of meditation starting in the 1960s, many people have experienced a variety of psychological difficulties, either while engaged in intensive spiritual practice or spontaneously. Grof and Grof (1989) have collected case reports of such persons. The more common presentations included mystical and near-death experiences noted above as well as kundalini awakening (a complex physio-psychospiritual transformative process described in the Yogic 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) (Lukoff, 1988). These problems present with varying intensity, ranging from a mild form of "spiritual emergence" (*i.e.*, a gradual unfolding of spiritual potential with no disruption in psychological/social/occupational functioning) to a severe form of "spiritual emergency" (*i.e.*, an uncontrolled emergence of spiritual phenomena with significant disruption in psychological/social/occupational functioning). Grof and Grof argue that the milder forms of spiritual emergence should not be diagnosed or treated as mental disorders but rather as developmental crises that can result in long-term improvement in overall well-being and functioning. The more severe forms of spiritual emergency, which some still view as developmental crises (Grof and Grof, 1990; Walsh, 1990), may precipitate forms of mental disorders or exacerbate preexisting disorders, requiring that an axis I or II disorder be coded along with religious or spiritual problem.

Meditation

Of the more common spiritual practices that have precipitated spiritual emergence/emergency phenomena, meditation is the most prominent in the literature. A wide range of potential psychotherapeutic benefits as well as adverse effects of meditative practice has been noted in the literature (Bogart, 1991; Murphy and Donovan, 1988; Shapiro and Giber, 1978; Walsh and

Roche, 1979). Walsh and Roche (1979) have attempted to identify individuals at risk for severe psychological disturbance, supporting the idea that an improper use of meditation does not generate new mental disorders but rather aggravates latent or preexisting ones. In addition, he has noted that altered perceptions may occur during initial phases of intensive meditation, but these are not necessarily pathological. The DSM-IV 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" (APA, 1994, p. 488). Such experiences, if distressing, should be categorized under religious or spiritual problem. In the case of meditative practice exacerbating a latent or preexisting disorder, religious or spiritual problem should be used in conjunction with the appropriate axis I or II disorder.

Separating from a Spiritual Teacher

Another example of a spiritual problem involves the difficulties that may arise when a person separates from his/her spiritual teacher. Bogart (1992) reviews the sources of various disturbances and unexpected problems that can occur in the relationship between a student and his/her teacher. Often students' eventual efforts to emerge from the "culture of embeddedness" with their teachers into more independent functioning in the world can be problematic, resulting in a transition that may require therapeutic intervention. Barring any preexisting mental disorder, such difficulties should be categorized under religious or spiritual problem.

Terminal Illness

Religious and spiritual practices and beliefs often influence the ways patients react to medical illness (Doka and Morgan, 1993; Krippner and Welch, 1992; Waldofel and Wolpe, 1993). 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. Religious and spiritual changes often occur during terminal illness (Aldridge, 1993), and comprehensive treatment should address these changes. Several articles have highlighted the value of consultation-liaison psychiatrists, doctors, and nurses working together with clergy in caring for dying patients (Conrad, 1985; Reed, 1987; Roche, 1989; Waldofel and Wolpe, 1993). Similarly, a number of recent articles have recommended that treatment of persons with acquired immune deficiency syndrome attend to the spiritual welfare of the patient (Aldridge, 1993, p. 9).

Addiction

Based on a literature review of studies on addiction,

Miller (1990) concluded that spiritual variables have been neglected in research. He recommended that measures of perceived purpose or meaning in life, changes in values and beliefs, shifts in religious practices, relationship of clients' religious value systems, acceptance of particular treatment goals and strategies, and the impact of spiritually oriented interventions on treatment outcome all be considered spiritual variables in research whose investigation "may improve our understanding of the addictive behaviors, and our ability to prevent and treat these enduring problems."

Twelve-step programs dominate addiction treatment, even in mental health settings, and spirituality plays a central role. One of the 12 steps mentions "a power greater than ourselves," the final step mentions a "spiritual awakening," five of the 12 steps make a specific reference to God, and the phrase "as we understand Him" appears twice. The founders of Alcoholics Anonymous 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 (Miller, 1990). Similarly, some theorists and clinicians within transpersonal psychology have approached addictions as spiritual crises (Grof, 1993; Small, 1991).

Overlap of Religious/Spiritual Problem and Mental Disorder

The change in the definition of Other Conditions That May Be a Focus of Clinical Attention noted above has introduced the challenge of assessing possible overlap between a mental disorder and a religious or spiritual problem. One example of such overlap would be those individuals with obsessive-compulsive disorder who present with self-reported scrupulous devoutness, which upon further assessment may simply be "the use of religion as a metaphor for the expression of compulsive requirements" (Salzman, 1986). In such cases, religious or spiritual problem could be coded along with obsessive-compulsive disorder if the preoccupation with religious issues was felt to be severe enough to warrant independent clinical attention.

Overlap between a mental disorder and a religious or spiritual problem is frequent among the psychotic disorders, especially manic psychosis. Podvoll (1987) has pointed out that manic psychotic episodes often contain mystical components. Goodwin and Jamison (1990) also have noted the prominence of religious and spiritual concerns in persons with manic-depressive illness. And Lukoff (1985) proposed new diagnostic categories of mystical experience with psychotic features and psychotic episode with mystical features to accommodate such overlap. In such cases, religious or spiritual problem could be coded along with the concomitant axis I disorder.

Cultural Sensitivity Issues

The earlier versions of the DSM have been criticized for not being culturally sensitive (Fabrega, 1992; Kirmayer, 1991; Kleinman, 1988; Mezzich et al., 1992). The focus on biological factors yields a diagnostic approach that relies largely on the assessment of decontextualized symptom clusters, despite findings that culture plays a major role in shaping the definition and expression of psychopathology (Brody, 1990). Highlighting the need for change, Mezzich et al. (1992) point out that by the year 2000, one third of the U.S. population will be composed of ethnically identified minorities, and that the world is currently 80% non-Western, with growing numbers of immigrants and refugees (p. 4). In addition, the United Nations World Health Organization estimates that over 70% of the world's population relies on nonallopathic systems of medicine (Mahler, 1977), and many traditional healers operating within such systems view patients' complaints as having spiritual etiologies (Westermeyer and Wintrob, 1979).

The importance of culturally sensitive clinical assessments is illustrated by Eisenbruch's (1992) description of the "cultural bereavement" syndrome that occurs among Cambodian refugees. He argues that their seemingly pathological symptoms (*e.g.*, reporting being visited by supernatural forces and yearning to complete obligations to the dead, as well as difficulties with daily functioning) result from their experience of being violently uprooted. When viewed from a culturally sensitive perspective, this may be a "normal, even constructive, existential response."

Answering this need for cultural sensitivity in the diagnostic nomenclature, the DSM-IV Task Force collaborated with an NIMH-sponsored Workgroup on Culture and Diagnosis, and made a number of important contributions. First, they produced an Outline for Cultural Formulation (APA, 1994) that provided "a systematic review of the individual's cultural background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction, and the effect that cultural differences may have on the relationship between the individual and the clinician" (p. 843). In the Outline, religion is explicitly mentioned only as a "cultural factor related to the psychosocial environment" that provides "emotional, instrumental and informational support" (p. 844). 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, such as the cultural identity of the individual, cultural explanations of the individual's illness, and the relationship between the individual and the clinician.

Second, the Committee compiled a Glossary of Culture-Bound Syndromes in the Appendix (APA, 1994),

including 23 of the best-studied "recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category" (p. 844). Several of these syndromes address problems that could be viewed as having religious or spiritual aspects. For example, "spell" involves "a trance state in which individuals 'communicate' with deceased relatives or with spirits" (p. 848). "Susto" (fright, or soul loss) is an "illness attributable to a frightening event that causes the soul to leave the body and results in unhappiness and sickness" (p. 848). In both cases, clinicians must examine the relationship between the syndrome and relevant DSM-IV categories. This includes various axis I disorders (e.g., brief psychotic disorder, major depressive episode, posttraumatic stress disorder) as well as the new nonpathological category of religious or spiritual problem.

Third, the Committee addressed specific cultural factors related to many of the axis I and axis II disorders (APA, 1994). Many of these factors demonstrate a greater sensitivity to religious or spiritual issues. For example, clinicians assessing for schizophrenia in socioeconomic or cultural situations different from their own must take religious/spiritual belief systems 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). Similarly, in evaluating the possible presence of schizotypal personality disorder, clinicians must be aware that "pervasive culturally determined characteristics, particularly those regarding religious beliefs and rituals, can appear to be Schizotypal to the uninformed outsider (e.g., voodoo, speaking in tongues, life beyond death, shamanism, mind reading, sixth sense, evil eye, and magical beliefs related to health and illness)" (p. 643).

Finally, as noted above, the Task Force accepted the new category religious or spiritual problem, acknowledging that religious and spiritual problems are not reducible to biological explanation and treatment. This culturally sensitive category requires that an individual's relationship to his or her culture's religious/spiritual practices, rituals, and beliefs be assessed and considered in the diagnostic decision. APA President John McIntyre (1994) discussed this development in his article on the improved dialogue between religion and psychiatry. He quoted Harold Pincus, director of APA's Office of Research, as saying that the new entry in DSM-IV on religion was "a sign of the profession's growing sensitivity, not only to religion but to cultural diversity generally" (McIntyre, 1994, p. 3).

Implications for Research

Religious and spiritual problems need to be subjected to more research to better understand their prevalence, clinical presentation, predisposing intrapsychic and interpersonal factors, outcome, relationship to the life cycle, and ethnic factors. Although there is a wealth of clinical literature on these problems, the clinical research on religious and spiritual problems is minimal, with the exception of the many well-designed studies on NDE. While defining discrete religious and spiritual problems for study clearly presents difficulties, the NDE research can serve as a model demonstrating that the obstacles are not insurmountable.

Two areas of particular importance for future clinical research would be differential diagnosis and treatment. With the previously noted change in the definition of Other Conditions That May Be a Focus of Clinical Attention, greater elaboration of the differential diagnostic spectrum, from religious/spiritual problems to mental disorders with religious/spiritual content, is essential. Better description of the multiple types of "pure" religious and spiritual problems (i.e., those religious and spiritual problems unrelated to any mental disorder) would help to establish the nonillness end of the spectrum. That, in turn, would highlight the need to address the co-existence of religious/spiritual problems with mental disorders at all other points along the spectrum. This would involve studying not only the incidence, prevalence, and presentation of such coexistence with each of the axes I and II disorders, but also the bi-directionality of such coexistence. Specifically, mental disorders may lead to religious or spiritual problems, and the converse may also be true.

A determination of the type, source, and intensity of a person's distress arising from a religious or spiritual problem would be important for treatment. The type of distress could be either primary (arising directly from the religious or spiritual experience at hand) or secondary (arising from the subsequent process of integrating the religious or spiritual experience). The source of distress could be either intrapsychic, interpersonal, or transpersonal (i.e., involving the transcendent), and the intensity of the distress could be quantified as mild, moderate, or severe. With these variables taken into account, the full range of treatment modalities could then be studied to determine which are most effective for which type of problem. Treatment guidelines could be established that would alert clinicians to effective traditional and nontraditional treatment modalities, and significantly decrease the iatrogenic harm from use of improper treatment.

Conclusion

In the face of psychiatry's longstanding tendency ei-

ther to ignore or pathologize the religious and spiritual dimensions of human existence, the inclusion of religious or spiritual problem in the DSM-IV marks a significant breakthrough. For the first time, there is an acknowledgment of psychological problems of a religious or spiritual nature that are not attributable to a mental disorder. In addition, this new category contributes to the greater cultural sensitivity incorporated into the DSM-IV. The authors hope this development will help to reverse the predicaments surrounding psychiatry's treatment of religious and spiritual issues, *i.e.*, "occasional, devastating misdiagnosis; not infrequent mistreatment; an increasingly poor reputation; inadequate research and theory; and a limitation of psychiatrists' own personal development" (Peck, 1993, p. 243). In addition, the use of this new category might increase mental health professionals' respect for individual beliefs and values, in line with the growing emphasis on cultural sensitivity. As a result, mental health professionals will be better equipped to deal with the religious and spiritual aspects of human experience that are central for many. Finally, the new diagnostic category could help to promote a new relationship between psychiatry and the fields of religion and spirituality that will benefit both mental health professionals and those who seek their assistance.

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