

# *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:

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

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

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# **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-Occurrence 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 issues. 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 spirituality has led to five broad areas of failure:  
occasional devastating misdiagnosis;  
not infrequent 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 Waelyt 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 Psychiatric 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 definition 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, PhD, 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 sequelae 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 sequelae 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. Pargament 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 Psychological 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.

*The 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 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. 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-religious 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

<p>REQUIRED QUIZ ITEM 8 Cult and Diet</p>
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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 beliefs 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**

- 1 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 experiences, some of which were problematic for their practitioners.

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. 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 American 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: Lightning 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.
- 10 Greyson, 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 Experiences* 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't already 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 critical component of clinical care is to recognize and diagnose episodes involving mystical 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 start 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 episode, 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 intuitive.

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 they are 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 intuition 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 revived 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 doses 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.

## DSM-IV Religious and Spiritual Problems

### LESSON 3.8 Shamanic Crisis

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

#### **Description**

Shamanism is humanity's oldest religion and healing art, dating back to the Paleolithic era. Originally, the word shaman referred specifically to healers of the Tungus people of Siberia. In recent times, that name has been given to healers in many traditional cultures around the globe who use consciousness altering techniques in their healing work.

Historically, shamanism has been confused with schizophrenia by anthropologists because shamans often speak of altered state experiences in the spirit world as if they were "real" experiences. While the shaman and the person in a psychotic episode both have unusual access to spiritual and altered state experiences, shamans are trained to work in the spirit world, while the psychotic person is simply lost in it.

But in many traditional cultures, psychotic episodes have served as an initiatory illness that calls a person into shamanism. Mircea Eliade writes:

The future shaman sometimes takes the risk of being mistaken for a "madman". . . but his "madness" fulfills a mystic function; it reveals certain aspects of reality to him that are inaccessible to other mortals, and it is only after having experienced and entered into these hidden dimensions of reality that the "madman" becomes a shaman. (Mircea Eliade. *Myths, Dreams, and Mysteries*. New York: Harper and Row, 1960. Page 80-81)

As the person accepts the calling and becomes a shaman, their illness usually disappears. The "self-cure of a psychosis" is so typical of the shaman that some anthropologists have argued that anyone without this experience should be described only as a healer. The concept of the "wounded healer" addresses the necessity of the shaman-to-be entering into extreme personal crisis in preparation of his/her role in the community as a healer (Halifax, Joan. *Shamanic Voices*. New York: Dutton, 1979)..

Traditional cultures distinguish between serious mental illness and the initiatory crisis experienced by some shamans-to-be. Anthropological accounts show that babbling confused words, displaying curious eating habits, singing continuously, dancing wildly, and being "tormented by spirits" are common elements in shamanic initiatory crises. In shamanic cultures, such crises are interpreted as an indication of an individual's destiny to become a shaman, rather than a sign of mental illness. If the illness occurs in an appropriate cultural context, the shaman returns from the crisis not only healed, but able to heal others.

For example, the Siberian shaman Kyzalov entered a state of "madness" lasting for seven years which resulted in his initiation as a shaman. He reported that during those years he had been beaten up several times, taken to many strange places including the top of a sacred mountain, chopped into pieces and boiled in a kettle, met the spirits of sickness, and acquired the drum and garment of a dead shaman. In our society today these experiences would be considered evidence of a psychotic disorder and could possibly result in hospitalization. Yet when Kyzalov recuperated, he reported that, "the shamans declared, 'You are the sort of man who may become a shaman; you should become a shaman. You must begin to shamanize.' " (Halifax, Joan. *Shamanic Voices*. New York: Dutton, 1979)..

Referring to the "wounded healer" concept, Kalweit argues the shamanic crisis is:

A sickness that is understood as a process of purification, as the onset of enhanced psychic sensitivity giving access to the hidden and highest potentials of human existence, is therefore marked by very different characteristics than those ascribed to pathological conditions by modern medicine and psychology, namely that suffering has only negative consequences. According to the modern view, illness disrupts and endangers life, whereas the shaman experiences his sickness as a call to restructure this life within himself so as to hear, see and live it more fully and completely in a higher state of awareness. (*Dreamtime and Inner Space: The World of the Shaman* by Holger Kalweit, p. 91)

### **Associated Clinical Problems**

Individuals in Western cultures occasionally experience similar problems:

We have seen instances where modern Americans, Europeans, Australians and Asians have experienced episodes that bore a close resemblance to shamanic crises...People experiencing such crises can also show spontaneous tendencies to create rituals that are identical to those practiced by shamans of various cultures. (Grof, S., & Grof, C. (Eds.). (1989). *Spiritual emergency: When personal transformation becomes a crisis*. Los Angeles: Tarcher). p. 14-15)

The themes common to shamanic crises include:

Descent to the Realm of Death, confrontations with demonic forces, dismemberment, trial by fire, communion with the world of spirits and creatures, assimilation of the elemental forces, ascension via the World Tree and/or Cosmic Bird, realization of a solar identity, and return to the Middle World, the world of human affairs. (Halifax, Joan. *Shamanic Voices*, p. 7)

But as with shamans in traditional cultures, when persons in this type of spiritual emergence receive proper guidance, they too can return from the experience positively

transformed. In a traditional society, shamans cure people's illnesses, guide recently deceased souls, and restore a community's psychic balance as well. For many people in contemporary western societies, shamanic crises are precipitants to their choice of a career in the health professions, such as psychology and nursing.

### **Treatment**

Treatment for people in a shamanic crisis follows the basic approach described in Lesson 6.1 Spiritual Crises. During the integration stage (Lesson 6.2 Psychotherapy), contact with traditional shamans and reading of literature on shamanism can be helpful adjuncts to therapy. In my own spiritual emergency, shamans played a role in recovery. The spiritual potential inherent in my experience lay dormant until contact with shamanic teachers enabled me to connect with that dimension. Years later, in the altered states of consciousness induced by shamanic practices, I re-experienced, for the first time since my psychotic episode, a feeling of oneness with the universe. Once again, I was communicating with divine spirits, and comprehending the meaning of life itself. Instead of repressing these ecstatic experiences which had brought painful memories, I was now learning to trust them again. Such experiences are a major component of shamanic life: "Shamans do not differ from other members of the collectivity by their quest for the sacred, which is normal and universal human behavior, but by their capacity for ecstatic experience" (Eliade *Shamanism*, p. 107). However, these teachers and their shamanic practices taught me how to exercise voluntary control over entry into and out of ecstatic states. I also learned how to keep them contained within appropriate social contexts. (Full account of how shamans helped with the integration phase).

### **Case Examples**

Traditional Initiatory Crisis

#### **WWW LIBRARY of Religion and Spirituality**

The WWW Library of Religion and Spirituality contains interviews with anthropologist Michael Harner, PhD, articles and guides to online resources.

REQUIRED QUIZ ITEM: 21

Shamanic Crisis

Shamanic crises occur

a) to individuals in traditional cultures b) to individuals in contemporary societies c) both a and b

Record your answer for later insertion into the Quiz.

## **DSM-IV Religious and Spiritual Problems**

### **LESSON 3.9 Alien Encounters**

**Description • Alien Encounter Experience and Psychopathology • Associated Clinical problems • Treatment • Case Examples • WWW Library**

#### **Description**

The recent (2000) book *Varieties of Anomalous Experience* published by the American Psychological Association Press includes this definition:

Alien abduction experiences are characterized by subjectively real memories of being taken secretly and/or against one's will by apparently non-human entities, usually to a location interpreted as an alien spacecraft (i.e., a UFO).  
(p. 254)

In addition to reports from the U.S., accounts from England, Mexico, Brazil, Chile and Australia show the same content themes:

capture, examination  
communication with aliens  
otherworldly journey  
theophany (receipt of spiritual messages)  
return to earth

Such extraordinary experiences, which to many seem sheer fantasy, are prevalent and cannot be ignored in clinical practice. Professionally, I personally have worked with schizophrenic and PTSD patients who have reported alien encounter experiences. I have also seen people with no mental disorder who reported such experiences.

John Mack, MD a Professor of Psychiatry at Harvard Medical School, makes the clinical case for the need to explicitly address such extraordinary experiences:

I began to see people in 1990 who seemed of sound mind but were describing experiences which simply did not fit into any kind of psychiatric category of which I could conceive. Child abuse, psychosis, neurosis, organic brain disease, fantasy-prone personality... No diagnostic category came close to explaining what I was seeing.

Studying *Intrusions from the Subtle Realm* audio or transcript of talk by John Mack, MD  
(free MP3 Player if needed)

Alien encounters are included within this course on religious and spiritual problems because such extraordinary events function for some individuals as transcendent experiences.

### **Prevalence**

Gallup Polls reveal how widespread beliefs are in UFO-related phenomena.. Fifty percent of a representative sample of the U.S. population reported that they believe there is life on other planets. This is up from 34% in 1966. UFO sightings are also widespread. The Gallup Poll asked a representative national sample:

Have you, yourself, ever seen anything you thought was a UFO?

12% answered Yes.

*The Next American Spirituality : Finding God in the Twenty-first Century* by Timothy Jones, George, Jr. Gallup

A 1997 Time/CNN poll found that 22% of Americans believe that the earth has been visited by space aliens. There are now thousands of cases of alien encounter published, and researchers have studied over 1700 cases. Whitley Strieber (who wrote *Communion* a best-selling book about his abduction experience) claims to have received over a quarter of a million letters from people about their similar experiences. Based on an extrapolation from a group of students, another researcher suggested 15 million Americans may have had such experiences. (Statistics from *Varieties of Anomalous Experience*, p. 256)

### **After Effects**

Both positive and problematic effects are reported by alien abduction experiencers. Bullard analyzed 270 abduction reports and found a range of physical and psychological after effects.

11 cases: Injuries such as cuts, bruises, & puncture wounds

22 cases: Eye problems

23 cases: Skin burns and irritation

13 cases Gastrointestinal distress

14 cases: Equilibrium and balance problems

12 cases: Thirst and dehydration

13 cases: Healing from a preexisting ailment

Fear, anticipation, anxiety, and recurring nightmares were also frequently reported, as were paranormal experiences and personality changes.

### **Association with Spirituality**

Many report that their lives have been radically altered on a deep spiritual level by their encounters with aliens. They developed a heightened reverence for nature and human life, and transformed their lives in ways similar to what happens with people after an NDE.

Kenneth Ring, PhD, Professor Emeritus of Psychology at the University of Connecticut and one of the world's chief authorities on near-death experiences, conducted research indicating that both alien abduction and NDE may be,

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*)

### **Reality of Alien Encounters**

Regarding the problematic question of the reality of the experience, Jung took the following position (that I share) regarding the physical reality of flying saucer reports, as they were called in the early 1950s:

As a psychologist, I am not qualified to contribute anything useful to the question of the physical reality of UFOs. I can concern myself only with their undoubted psychic aspects, and in what follows shall deal almost exclusively with their psychic concomitants.

(*Flying Saucers: A Modern Myth of Things Seen in the Skies*, p.7)

In fact, there have been accounts of moon beings since the days of Plutarch. With the advent of powerful new telescopes in the 1800's, there were many reported "sightings" of winged demons on the moon's surface. Current fascination with extraterrestrial life has achieved greater prominence than ever before, as evidenced by reports of encounters with space aliens in media news, nonfiction first person accounts such as *Communion*, science fiction literature and movies such as ET, Close Encounters of the Third Kind, and Signs. The question of extraterrestrial life has also become an important topic in stretching the scientific imagination to its limits..

Structurally there are parallels between alien encounters and ancient mythic patterns which can be traced back to 30,000 BC. The shaman's journey shares many elements with alien abduction. The abductee is taken taken aboard a spaceship ("other worlds" or a "cosmic pillar" in a shamanic journey), is forcibly examined (which parallels the painful dismemberment of the shaman). Then the abductee returns with a message (just as the shaman returns with songs and other instruments of healing). Ralph Metzner, PhD, considers space alien/UFO themes to be a variation of the shaman's "upper world journey":

experiences in which we are granted a preview or vision of our life or of some aspect of the world. They are usually accompanied by insights, intuitions, and new images; and they often instigate a mood of playful and euphoric creativity. (*The Unfolding Self: Varieties of Transformative Experience*, p. 118)

The concept of "believed in imaginings" (subjectively compelling distortions in the perception of reality) is also relevant to this question. Theodore R. Sarbin, PhD points out that the popular belief in the existence of angels is considered normal by mentally "healthy" people while belief in the existence of aliens is considered abnormal and a sign of mental illness. Yet, insofar as angels and aliens are both hallucinations (that is, self-reported imaginings), there is no difference between believing in angels and believing in aliens. Moreover, people who believe in angels are just as adamant in claiming the reality of angels as are those who insist on the reality of aliens. The difference between these two hallucinations has to do with the off-putting effect of these self-reported imaginings on others (See: Sarbin, T. Towards the Obsolescence of the Schizophrenia Hypothesis in *Challenging the Therapeutic State: Critical Perspectives on Psychiatry and the Mental Health System* by David Cohen, Editor).

### **Alien Encounter Experiences and Psychopathology**

While some patients have delusions involving alien abduction (I personally have worked with two patients who did [1], psychopathology cannot explain all of the phenomena associated with these experiences. A recent summary of research on Alien Abduction Experiences concluded,

While psychopathology is indicated in some isolated alien abduction cases, assessment by both clinical examination and standardized tests has shown that, as a group, abduction experiencers are not different from the general population in term of psychopathology prevalence.  
(*Varieties of Anomalous Experience*, p. 268)

John Mack, MD, who has studied over 200 alien abductees and written two books on this phenomenon during the past 10 years, found,

The reports, for example, surely sound delusional, or like hallucinations. They even defy our physical laws, suggesting some sort of psychosis. Abductees are often anxious, or suffer from bodily aches and pains, indicating some form of neurosis. Their recall of what they have been through is frequently spotty, so perhaps they have an organic impairment of the brain, for example temporal lobe epilepsy. The experiences are traumatic and often contain reproductive or sexual intrusions, which seems to point to a history of rape or possible childhood sexual abuse.

[However] Psychiatric evaluations and psychological studies of abductees, including several of my own cases, have failed to identify consistent psychopathology. Abductees may, of course, suffer from mental and emotional distress as a result of their often traumatic experiences, and a few have been found to have accompanying psychiatric conditions. Many come from troubled family backgrounds. But in no instance has the emotional disorder provided an explanation for the abduction experience. (See *Blowing the Western Mind* by John E. Mack, MD.)

In PEER's survey of abduction experiencers, the percentages of the sample seeking help for psychological symptoms were mostly comparable to the proportions in the general U.S. population:

- depressive symptoms (17 percent)
- schizophrenia (1 percent)
- bipolar (1 percent)

However, at 17%, the sample was about two times more likely to seek help for anxiety as the general population. The findings are similar to those of other researchers of encounter experiencers, who have found a low incidence of serious psychopathology among individuals reporting such experiences (John Mack, MD *Passport to the Cosmos: Human Transformation and Alien Encounters*). Thus a client's report of a alien encounter experience cannot be assumed to be related to psychopathology.

### **Associated Clinical Problems**

Alien encounter experiencers often suffer from post-traumatic symptoms such as nightmares, trouble concentrating, phobic avoidance of situations and objects symbolically linked to the encounter material

Other symptoms and potential problems following their experience include:

- Anxiety and irritability
- Intrusive thoughts about aliens and abduction
- Labile mood
- Disorientation, derealization, and depersonalization
- Psychic experiences presumed to be from an extraterrestrial source (e.g., telepathic messages)
- The belief that their thoughts are being shared with an extraterrestrial being
- Change in spiritual or religious values, beliefs, and practices
- (The Differential Diagnosis of Close Extraterrestrial Encounter Syndrome by Richard Boylan, Ph.D.)

In surveys returned to PEER on abduction experiences, 7 percent of the sample described their memories in a manner that made PEER staff wonder about preexisting or coexisting psychopathology because the reports showed pervasive lack of coherence, grandiosity, or paranoia. But for the rest, the experience itself seemed to be the major cause of distress and associated symptoms.

### **Treatment**

Some alien encounter experiencers seek therapy to help them integrate their anomalous experiences. The issue of hypnotizing such persons to obtain a fuller account of the experience is controversial and tied up with the larger debate about "false memories." Aggressive use of suggestive memory recovery procedures can increase distress and feelings of helplessness.

The risk of providing therapy can be minimized, and positive outcomes best assured, when the focus of treatment deals with education clients about possible explanations for the AAE, encouraging them to understand the AAE in terms of its meaning in their life, and otherwise working on coping strategies that transcend the inevitable inconclusiveness about the AAE's objective reality. (*Varieties of Anomalous Experience*, p. 271)

The Program for Extraordinary Experience Research (PEER) was established in 1993 by John Mack, MD to forge an approach to alien encounter experiences that addresses their clinical dimensions and also leads to a scientific understanding of the phenomenon.

PEER's efforts to deepen the understanding of abduction reports have shown that it is difficult in our culture to credit and trust extraordinary experiences...The listener attempting to comprehend what is being communicated may find it easier to dismiss the experience and the experiencer as irrational.

There are some unique challenges to working with alien experiencers. Many therapists find their own values challenged by the assertions of abductees, and this can interfere with their trust and empathy for the client:

What we hear may seem so bizarre or impossible from the standpoint of the world view in which we were brought up that our minds rebel and want to intervene with the reality-testing confrontations that psychiatrists know so well. But to do this would abort communication and destroy trust. We are, of course, aided in this curious "suspension of disbelief" by the fact that we are concerned only with the authenticity and honesty of the client's report, and the presence or absence of psychopathology or another biographical experience that might account for it. There is no injunction to establish the literal or material actuality of the reported experiences...I do not consider that abduction reports necessarily reflect a literal, physical taking of the human body (John Mack, MD *Passport to the Cosmos: Human Transformation and Alien Encounters*, p. 29, 31).

The clinical approach developed at PEER involves being able to tolerate not knowing about the reality status of the experience, while paying attention to the feelings and struggles of the person involved. PEER also uses a combination of hypnosis and a breathing technique as treatment in helping the abductees confront and move through the terrifying memories of the experiences.

Therapists also need to be sensitive to and acknowledge the growth potential in such extraordinary experiences. That speaks to the need to avoid judging the reported phenomena by the standards of normal awareness; rather, therapists should consider whether this unusual experience points to new possibilities for the client that are alternatives to or even superior to their prior functioning. As with other forms of spiritual emergency, therapy with alien abductees involves the integration of spiritual issues raised by the experience. The therapist's role is helping experiencers learn

what meaning these experiences have for them, and in what reality they hold the experiences. We are very clear in our work with them that we can never say for certain what these experiences are. This is a mystery. But they need to integrate and understand how to bring their experiences into their world.

PEER operates a clinic in the Boston area for both treatment and research. Clients are allowed to return as often as needed to integrate their experiences and obtain support while living in a society that does not recognize the vast new realms of the psyche to which they have been opened. They have published an

Integrating Extraordinary Experiences by Roberta Colasanti, LCSW

### **Case Examples**

From the Edge of Experience (available as text or MP3 audio file)

UFO Encounters -- Four Classic Cases

### **WWW LIBRARY of Religion and Spirituality**

The WWW Library of Religion and Spirituality includes interviews with John Mack, MD and articles on the symbolic and archetypal dimensions of alien experiences.

### **References**

1 Lukoff, D. (1988). Transpersonal therapy with a manic-depressive artist. *Journal of Transpersonal Psychology*, 20(1), 10-20.

#### **REQUIRED QUIZ ITEM 22**

Alien Encounters

UFO and Alien Encounter Experiences

a) are confined to people in certain cults b) are reported by millions of people c) are always associated with psychopathology

Record your answer for later insertion into the Quiz.

## **DSM-IV Religious and Spiritual Problems**

### **LESSON 3.10 Possession**

**Description • Possession and Psychopathology • Associated Clinical problems • Treatment • Case Examples • WWW Library**

#### **Description**

In possession, the person enters an altered state of consciousness and feels taken over by a spirit, power, deity, or other person who assumes control over his or her mind and body. Generally, the person has no recall of these experiences in the waking state. Such experiences have a long human history and many religions offer rituals and healings to protect participants from unwanted possession. The oldest theories about the etiology of mental disorders identify spirit possession as the causal agent. One of the signs of Christ's divinity was his ability to cast out demons from people who were possessed.

However, the deliberate induction of possession states is part of valued religious rituals in many cultures, and is probably the most popular form of union with the divine throughout human history. Possession-oriented rituals have been documented in accounts from ancient Egypt, and in the earliest forms of Kabbalistic practice. Possession was a recognized phenomenon in ancient Greece where the Delphi oracle spoke through women possessed by spirits. Possession is a central feature of Haitian voodoo ceremonies where specific deities are invited to 'ride' the bodies of the worshipers during ceremonies. It is also found in Balinese ritual drama where the dancers become the entity they are portraying.

Possession also appears in early Christianity in a positive light, particularly in the form of "speaking in tongues." Many contemporary forms of evangelical Christianity consider it desirable to be possessed by the Holy Spirit, with physical manifestations that include shaking and speaking in tongues. St. Paul was worried by the phenomenon, and found it necessary to lecture the Corinthian Christians on the need to carefully manage speaking in tongues:

If therefore, the whole church assembles, and all speak in tongues, and outsiders or unbelievers enter, will they not say that you are mad? . . .do not forbid speaking in tongues, but all things should be done decently and in order. (I Corinthians, 14)

Spirit possession cults have continued to proliferate, even in the secular West, and many spirits and their mediums are part of local as well as global cultures (Behrend and Luig, 2000). Possession states still occur both in the context of non-Judaeo-Christian religious practices and in some cases of initiation ceremonies involving ritual ordeals.

Anthropologist James Randall Noblitt, found that,

trauma is used in a variety of the initiation ceremonies which are conducted in preindustrial cultures and which may be associated with the development of possession states. Our theory is that ritual trauma is a primary cause of the dissociation of identity which one finds in shamanistic, and sorcery-oriented preindustrial cultures as well as the "occult underground" in modern Euro-America.

### **Possession and Psychopathology**

While possession is a common experience in many cultures, in Western industrialized cultures, such experiences are not normative and may lead to inappropriate diagnoses of dissociative or psychotic disorders. Anthropologist Ruth Inge-Heinz, PhD [1], who has studied possession experiences in many cultures, has commented on the deleterious effects of mislabeling an individual in a state of dissociation as having a mental disorder:

The concept of what constitutes a 'healthy mind' differs considerably from one culture to another...How devastating it can be to affix the label of 'mental illness' to any extraordinary state of consciousness! A dissociative state of mind does not necessarily qualify an individual for being put into a straight jacket. Many dissociative states occur in Southeast Asia, for example, in a culturally conditioned and controlled setting. (pp. 28–29)

The DSM-IV lists Dissociative Trance Disorder as a diagnosis requiring further study. Possession and possession trance are listed under the diagnosis Dissociative Disorder Not Otherwise Specified . The definition includes,

Possession trance, a single or episodic alteration in the state of consciousness characterized by the replacement of customary sense of personal identity by a new identity. This is attributed to the influence of a spirit, power, deity, or other person. (p. 729)

The *DSM-IV Casebook* includes a case example of this in which a woman reports,

"Sometimes God enters my body, which gets hot when I have visions." (p. 420)

In this state, she is presumed by herself and others to be possessed by dead ancestors, and to be able to foresee the future.

The Casebook notes that,

This woman has symptoms that would be considered psychotic if they were experienced by someone from a society that did not share the beliefs of her [Guinean] culture. She believes she has special powers and she has . . . hallucinations. In her local society, however, these phenomena are quite common. Her culture ascribes to her the role of healer and accepts her unusual experiences as normal for someone in that role. Indeed she is a successful healer. .

.Local culture would assign her the role as a healer, and her behavior would not be seen as something to be treated. (p. 421)

Despite this acknowledgment of the nonpathological nature of her experience in its cultural context, the Casebook, authored by many of the same people who developed the DSM-IV, assigns a diagnosis of a mental disorder to this case: Dissociative Disorder Not otherwise Specified!

Yet possession is also known to be associated with dissociative disorders that are not socially sanctioned and occur outside of the normal part of a collective cultural or religious practice. There is clearly a spectrum of dissociative experiences from nonpathological to pathological. (See Disintegrated experience: the dissociative disorders revisited)

Possessions are dysfunctional when there is impairment in social or occupational functioning or marked distress. The criteria described in Lesson 5 Differential Diagnosis can be helpful in making a differential diagnosis.

### **Associated Clinical Problems**

Possessed persons often feel their behavior is beyond their control. Bizarre behavior such as choking, projectile vomiting, frantic motor behavior, wild spasms, and contortions along with grotesque vocalizations can be a frightening experience both for the person possessed and for others witnessing it.

### **Treatment**

A key issue as with most spiritual emergencies is determining whether the person is in the midst of an episode of mental disorder or having a spiritual problem:

Demon possession and mental illness, then, are not simply alternative diagnoses. . Furthermore, demon possession is essentially a spiritual problem, but mental illness is a multifactorial affair, in which spiritual, social, psychological and physical factors may all play an aetiological role. The relationship between these concepts is therefore complex. Differential diagnostic skills may have a part to play in offering help to those whose problems could be of demonic or medical/psychiatric origin. However, spiritual discernment is of at least equal, if not greater, importance in such matters.

Chris Cook, Demon Possession and Mental Illness: Should we be making a differential diagnosis?

The differential diagnostic criteria described in Lesson 5 Differential Diagnosis should be used with special consideration for the patient's religious community and its practices. Support for the patient must include social integration of the experience within his/her community. The treatment guidelines in Lesson 6.1, especially those involving grounding, are especially important in coping with the physical aspects of possession. If the individual is connected with a group whose practices include possession, then

collaboration with leaders of that religious community should be part of the treatment plan.

### **Case Examples**

A Case Study of Possession in the Dojo  
by David Lukoff, PhD

### **WWW LIBRARY on Religion and Spirituality**

The WWW Library on Spirituality and Religion includes the Yahoo directory of possession and exorcism sites, accounts of possession, and scientific perspectives on dissociation.

### **References**

1 Heinze, R. I. (1982) Shamans or mediums: Toward a definition of different states of consciousness. *Journal of Transpersonal Anthropology*, 6(1&2), 25-44.

REQUIRED QUIZ ITEM: 23

Possession

Possession occurs

a) only to people in tribal cultures b) only ancient cultures such as early Christianity and Egypt c) throughout history and around the world d) rarely in contemporary societies

Record your answer for later insertion into the Quiz.

REQUIRED QUIZ ITEM: 24

Treatment of Possession

People in possession states should be...

a) given antipsychotic medications to quickly terminate the experience b) asked about their religious practices c) treated as prophets of their religion

Record your answer for later insertion into the Quiz.

## **DSM-IV Religious and Spiritual Problems**

### **LESSON 4 Co-Occurrence with Mental Disorders**

#### **Spiritual Issues of Persons with Mental Disorders • Co-Diagnosis with Axis I Disorders**

##### **Spiritual Issues of Persons with Mental Disorders**

As reviewed in Lesson 1 Background of DSM-IV Category, clinical literature has tended to pathologize religiosity in persons with mental disorders. One example is the assertion by Albert Ellis[1], that: "The less religious [patients] are, the more emotionally healthy they will tend to be" ( p. 637).

One study examined 44 psychiatric patients suffering from depression, anxiety disorders, and personality disorders to see if religious involvement was linked with neurotic behavior. Forty-five psychologically healthy subjects served as a comparison group. Results show that patients who had little or no religious commitment were just as likely to have depression, anxiety or other personality disorders as patients with higher levels of religious commitment. Being highly religious was not a risk factor for psychopathology, as has been often taught in mental health training programs.

Feifer S, Waelty U Psychopathology and religious commitment--a controlled study. *Psychopathology* 1995;28(2):70-7).

The recent (2001) *Handbook of Religion and Health* reviewed over 1600 studies, and found that across mental and physical disorders, religion is overwhelmingly associated with positive outcomes. There is evidence that religious practices speed recovery in mental disorders. For example, a recent study found that psychiatric patients who regularly attend church and pray recover more quickly than their nonreligious counterparts.

See Religious practices speed recovery in mental illness

Religious Coping May Reduce Hospital Stays for Psychiatric Patients

Therefore, therapy should consider the spiritual resources and needs of persons in recovery.

Studies have also found that hospitalized psychiatric patients are as religious as the general population, and they turn more to religion during crises. In The religious needs and resources of psychiatric inpatients, Fitchett et al., 1997 found that 88% of the psychiatric patients reported three or more current religious needs. Psychiatric patients had lower spiritual well-being scores and were less likely to have talked with their clergy. The study concluded that religion is important for psychiatric patients, and they may need assistance to find resources to address their religious needs.

One example of how religious beliefs can negatively affect health outcome is the belief that sin leads to one's illness. Of 52 psychiatric inpatients, 23% believed that sin-related factors, such as sinful thoughts or acts, cause illness. Such beliefs are associated with negative health outcomes.

Sheehan W, Kroll J Psychiatric patients' belief in general health factors and sin as causes of illness. *Am J Psychiatry* 1990 Jan;147(1):112-3

At St. Elizabeth's Hospital in Washington, D.C., the Chaplain Program conducts a "Spiritual Needs Assessment" on each inpatient, concluding with a treatment plan that identifies religious/spiritual needs and problems. The program defines the role of pastoral intervention and recommended religious/spiritual activities. (For a lesson on instruments and approaches to assessing spirituality, see the course on Spirituality and Recovery.)

### **Co-Diagnosis with Axis I Disorders**

In the DSM-IV, the diagnosis of Religious or Spiritual Problem is an Axis I condition and can be assigned along with a co-existing Axis I disorder. The APA Task Force on Religion and Psychiatry [2] reported: "The religious convictions of patients can be used effectively in therapy. Religion can be a usable support system for the patient even when the therapist believes the patient's religious system has no objective value."

Explicit and nonjudgmental attention to religious concerns can add significantly to the quality and effectiveness of clinical work. Indeed, struggles of faith are embedded in the life course of many patients in acute treatment. Religious and spiritual problems can be associated with the full range of DSM-IV mental disorders since the integrity of the individual is challenged in all illnesses.

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

Twelve Step programs such as Alcoholics Anonymous dominate addiction treatment in mental health settings, and religion/spirituality plays a central role. The first 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 A.A. 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. Jung told Bill W., the co-founder of A.A., that "craving for alcohol was the equivalent, on a low level, of the spiritual thirst of our being for wholeness." Jung maintained that recovery from addiction required a religious experience: "Inasmuch as you attain to the numinous experience, you are released from the curse of pathology." (See History of Early A.A.'s Spiritual Roots.) Similarly, some theorists and clinicians have approached addictions as essentially spiritual crises, not mental disorders [3].

The strong relationship between religious/spiritual commitment (e.g., church attendance) and the avoidance of alcohol and illicit drugs is well-established. However, not much is known about the religious/spiritual dimensions of addiction treatment. Religious/spiritual variables have been neglected in research. Such variables include measures of perceived

purpose or meaning in life, changes in values and beliefs, shifts in religious/spiritual practices, clients' religious/spiritual value systems, acceptance of particular treatment goals and strategies, and the impact of religious/spiritually-oriented interventions on treatment outcome. Miller recommended that these variables be considered in research in order to "improve our understanding of the addictive behaviors, and our ability to prevent and treat these enduring problems [4]." It is known that patients in alcohol treatment who become involved with a religious community after treatment have lower recidivism rates than those who do not. (See ICIHS Research Summaries.)

### **Obsessive-Compulsive Disorder**

In obsessive-compulsive disorder, some individuals present with what they consider scrupulous devoutness, but upon further assessment, the use of religion is a metaphor for the expression of compulsive requirements. 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 numbers of times; and the fear of performing the rituals incorrectly.

Greenberg and Witzum [5] describe an individual whose concern with correctly saying his prayers led him to spend nine hours a day in prayer instead of the usual 40-90 minutes of other ultra-orthodox Jews. Persons in this religious community with obsessive-compulsive disorder 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 to express compulsive needs. (However, the authors also concluded that ultra-orthodox Jews were not at higher risk for 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" (p. 557). When these religious factors warrant independent clinical attention and are explicitly addressed in treatment, Religious or Spiritual Problem should be coded along with Obsessive-Compulsive Disorder.

Greenberg and Witzum have proposed the following criteria for differentiating obsessive-compulsive behaviors from religious practices:

1. Compulsive behavior goes beyond the letter of the religious law.
2. Compulsive behavior is focused on one specific area and does not reflect an overall concern for religious practice.
3. The choice of focus of obsessive-compulsive behavior is typical of the disorder (e.g., cleanliness and checking, obsessive thoughts of blasphemy toward God or fear of illness).
4. Many important dimensions of religious life are neglected.

### **Psychotic Disorders**

Co-occurrence of a Religious and Spiritual Problems with psychotic disorders occurs frequently, especially in manic psychosis. One study of hospitalized bipolar patients

found religious delusions were present in 25% and their hallucinations were brief, usually grandiose, usually religious. Goodwin and Jamison (Manic-Depressive Illness) have also noted the prominence of religious and spiritual concerns in persons with manic-depressive illness. They suggest that there, "have been many mystics who may well have suffered from manic-depressive illness--for example, St. Theresa, St. Francis, St. John" (p. 362). Mystical features can occur along with a psychotic disorder. For such patients, Religious or Spiritual Problem could be coded along with the concomitant Axis I disorder.

There is cross-cultural support for the overlap of psychosis and religious experiences. Anthropologists have observed that,

highly similar mental and behavioral states may be designated psychiatric disorders in some cultural settings and religious experiences in others...Within cultures that invest these unusual states with meaning and provide the individual experiencing them with institutional support, at least a proportion of them may be contained and channeled into socially valuable roles. (Prince [6])

In Ken Wilber's [7] spectrum model of consciousness, psychosis is neither prepersonal (infantile and regressive) nor transpersonal (transcendent and absolute); it is depersonal--an admixture of higher and lower elements:

[Psychosis] carries with it cascading fragments of higher structures that have ruinously disintegrated" (p. 64). Thus, psychotic persons "often channel profound spiritual insights. (p. 108)

But psychotic persons are incapable of differentiating the transpersonal from the regressive prepersonal at the time of the experience. Afterwards, while in recovery, they are often able to sort through their experiences and separate the wheat from the chaff. Psychotherapy can salvage the valid religious/spiritual dimensions of the experience. James Hillman has stated that recovery means recovering the divine from within the disorder, seeing that its contents are authentically religious.

Transpersonal psychotherapy can be especially valuable in the postpsychotic period because it promotes the integration of the healthy parts of religious/spiritual experiences in psychosis. (See Lesson 6.2 on Psychotherapy)

Jerome Stack, a Catholic Chaplain for 25 years at Metropolitan State Hospital in Norwalk, California, observed that many people with mental disorders do have genuine religious experiences:

Many patients over the years have spoken to me of their religious experiences and I have found their stories to be quite genuine, quite believable. Their experience of the divine, the spiritual, is healthy and life-giving. Of course, discernment is important, but it is important not to presume that certain kinds of religious experience or behavior are simply "part of the illness."

During manic episodes in particular, people have experiences similar to those of the great mystics.

Sally Clay, an advocate and consultant for the Portland Coalition for the Psychiatrically Labeled, has written about the significant role that religious experiences played in her recovery. She had been hospitalized for two years diagnosed with schizophrenia at the Yale-affiliated Hartford Institute of Living (IOL). While there, she had a powerful religious experience which led her to attend religious services.

My recovery had nothing to do with the talk therapy, the drugs, or the electroshock treatments I had received; more likely, it happened in spite of these things. My recovery did have something to do with the devotional services I had been attending. At the IOL I attended both Protestant and Catholic services, and if Jewish or Buddhist services had been available, I would have gone to them, too. I was cured instantly--healed if you will--as a direct result of a spiritual experience.

Many years later Clay went back to the IOL to review her case records, and found herself described as having "decompensated with grandiose delusions with spiritual preoccupations." She complains that "Not a single aspect of my spiritual experience at the IOL was recognized as legitimate; neither the spiritual difficulties nor the healing that occurred at the end."

Clay is not denying that she had a psychotic disorder at the time, but makes the case that, in addition to the disabling effects she experienced as part of her illness, there was also a profound spiritual component which was ignored. She describes how the lack of sensitivity to the spiritual dimensions of her experience on the part of mental health and religious professionals was detrimental to her recovery. Nevertheless, she has persevered in her belief that,

For me, becoming "mentally ill" was always a spiritual crisis, and finding a spiritual model of recovery was a question of life or death. Finally, I could admit openly that my experiences were, and always had been, a spiritual journey--not sick, shameful, or evil.  
The Wounded Prophet by Sally Clay

Mental health programs can, through their structures and culture, create environments that promote this spiritual work. New Recovery Center at Boston University is an example of a program that has adopted a recovery model incorporating a spiritual component. Curricular options include such courses as "Connectedness: Some Skills for Spiritual Health," "Hatha Yoga," and a "Recovery Seminar." This guided exploration of personal recovery is the center's flagship course.

People recovering from mental disorders have rich opportunities for spiritual growth, along with challenges to its expression and development. They will find much-needed support for the task when they are guided to clinically explore to explore their spiritual lives.

For more information on integrating spirituality into recovery, see the Internet Guided Learning course

### Spirituality & Recovery from Mental Disorders

#### References

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- 2 American Psychiatric Association. (1990). "Guidelines regarding possible conflict between psychiatrists' religious commitments and psychiatric practice." *American Journal of Psychiatry* 147: 542.
- 4 Grof C (1993) *Thirst for wholeness: Attachment, addiction and the spiritual path*. San Francisco: HarperCollins.
- oka & J. Morgan (Eds.), *Death and spirituality*. Amityville, NY: Baywood.
- 4 Miller, W R (1990) *Spirituality: The silent dimension in addiction research*. *Drug and Alcohol Review* 9:259-266.
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- 7 Wilber, K. (1993) *The pre/trans fallacy*. In Walsh, R. Vaughan, F. (Eds.) *Paths Beyond Ego*. Los Angeles: Tarcher.

#### REQUIRED QUIZ ITEM 25

##### Religiosity of Patients

Psychiatric patients are

- a) more religious than the general public b) less religious than the general public c) as religious as the general public

Record your answer for later insertion into the Quiz.

#### REQUIRED QUIZ ITEM: 26

##### Diagnosis

Religious or Spiritual Problem cannot be assigned as an Axis I diagnosis along with an Axis I Disorder.

True

False

Record your answer for later insertion into the Quiz.

## **DSM-IV Religious and Spiritual Problems**

### **LESSON 5.1 Differential Diagnosis**

#### **Differential Diagnosis of Intense Spiritual Crisis & Psychotic Disorders • Diagnostic Criteria for Spiritual Emergency • Differential Diagnosis of Intense Religious Experiences & Psychotic Disorders • Case Example**

##### **Differential Diagnosis of Spiritual Crisis & Psychotic Disorders**

The DSM-IV highlights the need for cultural sensitivity when clinicians assess for schizophrenia in socioeconomic or cultural situations different from their own:

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)

Criteria for making the differential diagnosis between psychopathology and authentic spiritual experiences have been proposed by Agosin [1], Grof and Grof [2] and Lukoff [3]. There is considerable overlap among the proposed criteria. Ken Wilber argues that confusion in distinguishing intense spiritual experiences from psychosis has been created by failing to make the critical distinction between pre-rational states and authentic transpersonal states. This "pre/trans fallacy" has been perpetuated:

Since both prepersonal and transpersonal are, in their own ways, nonpersonal, then prepersonal and transpersonal tend to appear similar, even identical, to the untutored eye. (Wilber, p. 125 [4])

The diagnostic criteria listed below were originally published in the *Journal of Transpersonal Psychology* in 1985, in an article entitled *Diagnosis of Mystical Experience with Psychotic Features*. The use of operational criteria is intended to identify cases of spiritual emergency with a high degree of accuracy (validity) and consistency across different diagnosticians (reliability). The specific criteria proposed below represent hypotheses that must be subjected to studies to determine whether they achieve acceptable levels of interrater agreement and whether they accurately identify positively transforming experiences.

##### **Diagnostic Criteria for Spiritual Emergency**

Phenomenological overlap with one of the types of spiritual emergency  
 Prognostic signs are indicative of a positive outcome  
 The person is not a significant risk for homicidal or suicidal behavior

### **1. Phenomenological overlap with one of the types of spiritual emergency**

Criterion 1 is based on the clinician's ability to recognize phenomenological characteristics of the types of spiritual emergency. I have proposed five criteria by which phenomenological overlap with a mystical experience can be identified. Assessment of overlap for other types can be based on the phenomenology as described in Lesson 3 Types of Spiritual Problems on. The criteria below are presented as an example for Mystical Experience problems.

#### a) ecstatic mood

The most consistent feature of the mystical experience is elevation of mood. Laski (1968) describes it as a state with "feelings of a new life, another world, joy, salvation, perfection, satisfaction, glory" (cited in Perry [5] p. 84). Bucke [6] examined the experiences of well-known mystics, leaders, and artists, as well as his own mystical experience, and noted they all shared "a sense of exultation, of immense joyousness (p. 9). James [7] also points to the "mystical feeling of enlargement, union and emancipation" (p. 334), and claims that "mystical states are more like states of feeling than like states of intellect" (p. 300).

#### b) sense of newly-gained knowledge

Feelings of enhanced intellectual understanding and the belief that the mysteries of life have been revealed are commonly reported in mystical experiences (Leuba [8]). James [7] describes this phenomenon of newly-gained knowledge ("gnoesis") as states of insight into the depths of truth unplumbed by the discursive intellect. They are illuminations, revelations, full of significance and importance (p. 33). Jacob Boehme, a seventeenth-century shoemaker whose mystical experience ushered in a new vocation as a nature philosopher, reported: "In one-quarter of an hour, I saw and knew more than if I had been many years together at a university. For I saw and knew the being of all things" (cited in Perry [5] p. 92).

#### c) perceptual alterations

Mystical experiences often involve perceptual alterations ranging from heightened sensations to auditory and visual hallucinations. Boehme felt himself surrounded by light during his mystical experience. Visual and auditory hallucinations with religious content are also common, e.g., Saint Therese saw angels and Saint Paul heard the voice of Jesus Christ saying "Paul, Paul, why persecutest thou me?" (Acts: 3-4).

#### d) delusions with specific themes related to mythology

James [7] and Neuman [9] have both commented on the diversity of content in mystical experiences across time and cultures. The mystical experience does not have

specific intellectual content of its own. It is capable of forming matrimonial alliances with material furnished by the most diverse philosophies and theologies. (James [7] p. 333)

Electronic media have greatly increased the repertoire of cultural material available for incorporation into both mystical and psychotic experiences. Individuals who in the past might have claimed to be St. Luke, may now claim to be Luke Skywalker.

However, John Perry, MD, points out that below the surface level of specific identities and beliefs are thematic similarities in the accounts of patients whose psychotic episodes have good outcomes:

There appears to be one kind of episode which can be characterized by its content, by its imagery, enough to merit its recognition as a syndrome. In it there is a clustering of symbolic contents into a number of major themes strangely alike from one case to another (p.9).

Based on Perry's research and other accounts of patients with positive outcomes, the following eight themes were identified as occurring commonly in spiritual emergencies

1. Death: being dead, meeting the dead or meeting Death
2. Rebirth: new identity, new name, resurrection, apotheosis to god, king or messiah
3. Journey: Sense of being on a journey or mission
4. Encounters with Spirits: demonic forces and/or helping spirits
5. Cosmic conflict: good/evil, communists/Americans, light/dark, male/female
6. Magical powers: telepathy, clairvoyance, ability to read minds, move objects
7. New society: radical change in society, religion, New Age, utopia, world peace
8. Divine union: God as father, mother, child; Marriage to God, Christ, Virgin Mary, Radha or Krishna

In contrast, not all delusions have content related to the eight mythic themes described above. The following statements from schizophrenic patients with whom I have worked illustrate different themes.

My brain has been removed.

A transmitter has been implanted into my brain and broadcasts all my thoughts to others.

My parents drain my blood every night.

The Mafia is poisoning my food and trying to kill me.

My thoughts are being stolen and it interferes with my ability to think clearly.

The person claiming to be my wife is only impersonating her; she's not my wife.

Familiarity with the range and variation of content in myth, religion and psychosis is essential for determining which delusions have mythic themes.

e) absence of conceptual disorganization

Some psychotic patients have cognitive deficits which cause them difficulty with their basic thought processes. For example, a person with schizophrenia complained, "I get lost in the spaces between words in sentences. I can't concentrate, or I get off onto thinking about something else" (in Estroff [10] p. 223). Systematic comparisons of first person accounts of mystical experiences and schizophrenia have found that "Thought blocking and other disturbances in language and speech do not appear to accompany the mystical experience" (Buckley p. 521). Therefore, the presence of conceptual disorganization, as evidenced by disruption in thought, incoherence and blocking, would indicate the person is experiencing something other than a spiritual emergency.

## 2. Prognostic signs are indicative of a positive outcome

Criterion 2 is based on research-validated good prognostic indicators that help predict positive long term outcome. The features listed below are based on a survey of the outcome literature (Lukoff, 1986). Good prognostic indicators include:

- 1) good pre-episode functioning
- 2) acute onset of symptoms during a period of 3 months or less
- 3) stressful precipitant to the psychotic episode
- 4) a positive exploratory attitude toward the experience.

## 3. The person is not a significant risk for homicidal or suicidal behavior

Criterion 3 concerns issues which might require treatment in a restricted environment. Psychotic disorders can be the basis for homicidal and suicidal behaviors. Both John Lennon and President Reagan were shot by persons with previously diagnosed psychotic disorders. Arieti & Schreiber [11] have described the case of a multiple murderer whose auditory hallucinations from God and delusions of being on a religious mission fueled his bizarre and bloody killings.

Assessment of dangerousness and suicidality are legal responsibilities of licensed mental health professionals. This exclusionary criterion should be implemented only if the danger seems imminent. Behavior which appears bizarre, but presents no risk to self or others, does not warrant use of this criterion.

Even with the use of these criteria, it is often difficult to distinguish spiritual emergencies from episodes of mental disorder. Agosin (1991) has pointed out that, "Both are an attempt at renewal, transformation, and healing" (p. 52).

Zen Master Jakusho Kwong Roshi observed that powerful spiritual awakenings can have varied outcomes,

Anybody with a body and mind can experience realization. Often they don't tell anybody because they think it is strange. They either keep it quiet, go crazy, or their search leads them to a teacher who can explain their situation.

### **Differential Diagnosis of Intense Religious Experiences and Psychotic Symptoms**

Based on their experience working with an ultra-orthodox Jewish sect in Israel, Greenberg and Witzum [12] have proposed the following criteria to distinguish between normative strictly religious beliefs and experiences from psychotic symptoms:

1. Psychotic experiences are very personal, e.g., may involve special messages from religious figures.
2. The details of psychotic experiences exceed accepted beliefs, e.g., they are more intense than normative religious experiences in their religious community.
3. The person in a psychotic episode may be terrified by the experience rather than excited by it.
4. The person in a psychotic episode is preoccupied by the experience and can think of little else.
5. The onset of the experience is associated with deterioration of social skills and personal hygiene.

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, can preoccupy the individual for a period of time, and can lead to the performance of private rituals. In addition, Greenberg and Witzum (1991) point out that,

Differentiating religious beliefs and rituals from delusions and compulsions is difficult for therapists ignorant of the basic tenants of that religion. (p. 563)

### **Case Example**

The application of these diagnostic criteria is illustrated in the

#### Diagnostic Example

REQUIRED QUIZ ITEM: 27

Hearing Voices

Hearing voices when no one is present is

a) a sign of a spiritual emergency b) a symptom of a mental disorder c) potentially a or b

Record your answer for later insertion into the Quiz.

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## **DSM-IV Religious and Spiritual Problems**

### **LESSON 6.1 Therapeutic Interventions: Spiritual Crises**

#### **Overview of Treatment • Therapeutic Interventions for Acute Crises • Case Example**

##### **Overview of Treatment**

The Mystical, Near-Death, Meditation and Spiritual Practice, Visionary and Shamanic types of spiritual problems have been associated with crises ("spiritual emergencies") where a person has difficulty functioning. Each of these problems has a section on Therapy

- Mystical experiences
- Near-death experiences
- Meditation and Spiritual Practice
- Visionary experiences
- Shamanic experiences

There are also a number of therapeutic strategies that apply to all spiritual crises. Stanislav Grof, MD, and Christina Grof, founders of the Spiritual Emergence Network, describe a spiritually-sensitive approach:

The most important task is to give people in crisis a positive context for their experiences and sufficient information about the process that they are going through. It is essential that they move away from the concept of disease and recognize the leading nature of their crisis...

Whether attitudes and interactions in the narrow circle of close relatives and friends are nourishing and supportive or fearful, judgmental, and manipulative makes a considerable difference in terms of the course and outcome of the episode...

[Therapy] should not be limited to talking and should allow full experience and direct release of emotion. It is absolutely essential to respect the healing wisdom of the transformative process, to support its natural course, and to honor and accept the entire spectrum of human experience  
(*Spiritual Emergency: When Personal Transformation Becomes a Crisis*, p. 195)

Interventions can range from support for a time-limited crisis, with possible involvement of relatives, friends, support groups, and medical persons, to intensive long-term psychotherapy. Choice of specific interventions depends on the intensity, duration, and type of spiritual problem, and also on the individual and their support network.

### **Therapeutic Interventions for Acute Crises**

Therapy with spiritual emergency patients in crisis ("spiritual emergency") can include the following 9 interventions:

- Normalize
- Create a therapeutic container
- Help patient to reduce environmental and interpersonal stimulation
- Have patient temporarily discontinue spiritual practices
- Use the therapy session to help ground the patient
- Suggest the patient eat a diet of "heavy" foods and avoid fasting
- Encourage the patient to become involved in simple, grounding, calming activities
- Encourage the patient to draw, mold clay, make music, journal, write poetry, dance
- Evaluate for medication

### **Normalize**

People in the midst of intense spiritual experiences need a framework of understanding that makes sense of them. Mental health theory has provided little guidance in this area, and has often pathologized religious and spiritual experiences. Often it is the lack of understanding, guidance and support that allows such experiences to go out of control. Jung described how providing a normalizing framework helped in the following case:

I vividly recall the case of a professor who had a sudden vision and thought he was insane. He came to see me in a state of complete panic. I simply took a 400-year-old book from the shelf and showed him an old woodcut depicting his very vision. "There's no reason for you to believe that you're insane," I said to him. "They knew about your vision 400 years ago." Whereupon he sat down entirely deflated, but once more normal (Man and His Symbols, p. 58).

In a similar way, Ram Dass, a spiritual teacher, originally trained as a clinical psychologist, helped a person in distress by framing his experience as a kundalini reaction. He recounted a telephone call from someone saying he thought he was going crazy. After the caller described uncontrollable tearfulness and so much energy he couldn't sleep, Ram Dass said,

Let me read you a list of symptoms, I have a Xerox. It's just mother Kundalini at work.  
(*Spiritual Emergency: When Personal Transformation Becomes a Crisis*, p. 181)

Brant Cortright, PhD, describes the clinical value of educating the patient and significant others:

Education about spiritual emergency serves two primary functions. First, it gives the person a cognitive grasp of the situation, a map of the territory he or she is

traversing. Having a sense of the terrain and knowing others have traveled these regions provides considerable relief in itself.

Second, it changes the person's relationship to the experience. When the person (and those around him or her) shifts into seeing what is occurring as positive and helpful rather than bad and sick, this changes the person's way of relating to the experience. To know that this process is healing and growthful permits the person to turn and face the inner flow of experiences, to welcome them rather than turning away or trying to suppress them (*Psychotherapy and Spirit*, p. 173)

The term spiritual emergency is one that describes and normalizes such crises. It provides a nonpathological understanding and is a gateway for patients, family and friends to the rapidly developing literature on these types of problems.

Ed Podvoll, MD, a psychiatrist who has used Buddhist approaches including compassion and mindfulness training with patients, points out that this is not an easy process:

The difficult task becomes the need to shift one's view from seeing the experience as a totally destructive cataclysm to being able to see and appreciate the constructive attempt at self-transcendence, to see that its conscious goal is not a relinquishing of life but an attempt at renewal. (*The Seduction of Madness*, p. 587).

Usually, the patient's family and friends play a critical role in implementing and maintaining the spiritual and grounding interventions described below. Therefore, they also need to be educated about the potential for positive transformation and how to support a person in spiritual crisis.

### **Create a therapeutic container**

John Perry, MD, who founded Diabysis, a residential treatment center for working with people in visionary psychotic states, emphasized that when a person's psyche is energized and activated, what he or she needs is contact with a person who empathizes, who actively encourages the process, who provides a loving appreciation of the qualities emerging through the process, and who facilitates the process rather than attempting to halt or interfere with it. Brant Cortright, PhD highlights the qualities required of the therapist:

In spiritual emergency, the personal presence of the therapist is key. Although some people are able to sail these waters successfully by themselves, for many people the presence of one or more wise compassionate guides on this journey can be of enormous help...Warmth and compassion combined with a degree of softness and gentleness are essential, for hardness, coldness, or insensitivity can be highly jarring to the delicate and refined perceptions of a person undergoing these consciousness changes. Additionally, a certain calmness and quiet confidence serves to energetically reassure and soothe the apprehension and alarm that are frequently present (*Psychotherapy and Spirit*, p. 174).

### **Help patient to reduce environmental and interpersonal stimulation**

The person undergoing a spiritual emergency needs to be shielded from the psychic stimulation of the everyday world, which is usually experienced as painful and interfering with the inner process. The therapist needs to work with the patient to determine the specific people and situations that exacerbate the dysfunctional aspects of the spiritual emergency.

### **Have patient temporarily discontinue spiritual practices**

Meditation has triggered many reported spiritual emergencies. Meditation teachers who hold intensive retreats are familiar with this form, and have developed strategies for managing such occurrences (case example). Yoga, Qi gong, and other spiritual practices can also be triggers. Usually teachers advise ceasing the practice temporarily. It can be reintroduced as the person becomes more stable.

### **Use the therapy session to help ground the patient**

Therapy sessions can be used in various ways depending on the phase of spiritual emergency, and its specific features. In the case vignette below, Stuart Sovatsky, PhD, Clinical Director of the Kundalini Clinic, gives an example from his psychotherapy practice of grounding a patient in a spiritual emergency into the present during the therapy session:

Client: I'm, overwhelmed, (crying, sobbing) with this kundalini, I can't take it anymore, I don't know what to do.

Therapist: (Talking right over the client, simultaneously). You have an amazingly musical voice, I hear it as you are sobbing.

Client: I have been a singer, I want to be one."

Therapist: Then that will be a big part of our goal. That goal will channel a lot of this energy into a creative outlet, the vishuddha chakra, the throat wants to sing, you want to sing.

The client listened for half of what I said, then eyes went down and sobbing returned.

Therapist: Please, look back at me, you slipped back out of rapport with me and into your cycling thoughts of despair. Look. See, I am actually admiring you, which I do. I admire how courageous you are, coming to a stranger out of the hope that he could help. I admire your ability to trust, yes, yes, NOW you are growing in your trust of me, I see it in your eyes as you look (Client smiles).

This is our cooperative relationship....This "looking" is the beginning of open-eyed meditation that grounds the client in time/space, so she won't drift back into her mind-chatter of despair.

### **Suggest the patient eat a diet of "heavy" foods and avoid fasting**

Grains (especially whole grains), beans, dairy products, and meat are considered grounding ("heavy") foods as opposed to fruit and fruit juices, salads. Sugar and stimulants like caffeine are also not advised.

Encourage the patient to become involved in simple, grounding, calming activities. Gardening is one such activity, or any simple tasks, such as knitting, housecleaning, shoveling, sorting. Encourage the patient to participate in regular exercises. Walks are probably the best way to help a person bring their consciousness back into their body. Walks in nature have the added benefit of enhancing tranquility and a calm mind. If the patient is a regular participant in other activities such as swimming or biking, they could engage in that. However, competitive sports would be too stimulating.

Encourage the patient to draw, paint, mold clay, make music, journal, write poetry, dance, both in the sessions and at home. These creative arts can help a person express and work through their inner experience. The language of symbol and metaphor can help integrate what can never be fully verbalized.

### **Evaluate for medication**

Some practitioners, such as John Perry, MD, have argued that medication only inhibits a person's ability to concentrate on the inner work and it mutes the psychic energy needed to sustain the effort to move the process forward. When medication is used to simply repress the inner process, it becomes frozen in an unfinished state. Suppression can impede the potential for a complete working through to a point of resolution.

Sometimes the process is so intense that the person is overwhelmed and becomes very anxious. That person could benefit from slowing down the process. Bruce Victor, MD, a psychiatrist and psychopharmacologist, uses low doses of tranquilizing or antipsychotic medication to alleviate some of the most distressing feelings and allow the person to better assimilate the experience.

The resolution of this seeming contradiction lies in the assessment of whether the presence of the debilitating state serves the function of psychological growth. Although the experience of pain, whether psychological or physical, can be a powerful motivator for personal change, its persistence beyond a certain point can retard it...

It becomes a challenge to determine whether the person can actively work with the pain therapeutically toward further psychological growth...One important role of pharmacotherapy is to titrate the level of symptoms, whether they be pain, depression, anxiety, or psychotic states, so that they can be integrated by the person in the service of growth. (*Textbook of Transpersonal Psychiatry and Psychology*, p. 332)

Some psychiatrists with a sensitivity to the spiritual emergency process have discussed their methods at conferences. Their approach is to prescribe dosages of medication that dampen down the inner process so the patient can continue work on an outpatient basis instead of an inpatient basis (e.g., Robert Turner, MD). Medication practices have already been influenced by new understandings of spiritual emergencies. For example, Bruce Greyson, MD reports that persons in intensive care units (ICU) who report out-of-body experiences and encounters with angels are no longer seen as having "ICU psychoses" requiring treatment with antipsychotic medication.

The major criterion I use in deciding whether to make a referral for medication evaluation is whether the person is in a situation which can support his/her involvement in intensive inner process. A person living in a communal setting, such as a spiritual retreat center, can go much deeper while being cared for physically and supported in working through the crisis. I observed this at The Ojai Foundation, a retreat center, when a person went into a spiritual emergency that required round-the-clock attention. The community provided full-time support for 2 weeks until she could maintain on her own.

However, people living in less supportive environments often do need to maintain themselves at a higher level of functioning. Otherwise, they risk hospitalization, loss of their livelihood, living situation, and other essentials. I have referred such individuals for medication if I assessed that they were a risk to themselves in this way. I would always refer for a medication evaluation if I thought a patient might be a risk to others, but this is rare in a spiritual emergency. However, spiritual emergency patients can engage in risky behaviors such as driving recklessly, which does endanger others. Therefore, a risk assessment is part of an assessment for medication and must take into account the spiritual emergency patient's support system. Of course, any use of medication should be with the full understanding and consent of the person, who should be an active participant in the decision-making.

### **Case Example**

Emma Bragdon describes her personal crisis which involved questioning of spiritual values.

Separating From a Spiritual Teacher can lead to a loss of spiritual connection as the individual questions, and then severs, the social support for that belief system and set of practices.

#### **REQUIRED QUIZ ITEM 28**

Meditation

Meditation is always a good intervention for spiritual crises.

True

False

Record your answer for later insertion into the Quiz.

**REQUIRED QUIZ ITEM 29****Medication**

Medication is always contraindicated in spiritual crises.

True

False

Record your answer for later insertion into the Quiz.

## **DSM-IV Religious and Spiritual Problems**

### **LESSON 6.2 Psychotherapy**

**Spiritual Interventions in Psychotherapy • Role of Psychotherapy • Phase 1: Telling the Story of the Experience • Phase 2: Tracing the Symbolic/Spiritual Heritage • Phase 3: Creating a New Personal Mythology**

#### **Spiritual Interventions in Psychotherapy**

Spiritual interventions can be essential to facilitating recovery and change. At times these could include:

- Educating the patient about the spiritual emergence process that is part of a spiritual journey with a potentially positive outcome
- Encouraging the patient's involvement with a spiritual path or religious community that is consistent with their experiences and values
- Encouraging the patient to seek support and guidance from a credible and appropriate religious or spiritual leaders
- Encouraging the patient to engage in religious and spiritual practices consistent with their beliefs (e.g., prayer, meditation, reading spiritual books, acts of worship, ritual, forgiveness and service)
- Modeling his/her own spirituality (when appropriate), including a sense of spiritual purpose and meaning, hope, and faith in something transcendent

#### **Role of Psychotherapy**

Psychotherapy can help patients with religious and spiritual problems to shape their experience into a coherent narrative, to see the "message" contained in their experiences, and to create a life-affirming personal mythology that integrates their spiritual problem. These three phases of psychotherapy are directed toward that integration are described below. In addition, spirituality plays a special role in psychotherapy with such patients.

#### **Phase 1: Telling the Story of the Experience**

Psychotherapy can be seen as a process of helping clients construct a new narrative, a fresh story of their lives. Psychotherapy does not consist in the cathartic healing effect of releasing traumatic repressed events and their emotions, but in reconstructing a person's authentic story (See *What is narrative therapy?*). In making interpretations, the therapist retells the patient's story, and these retellings progressively influence the what and how the story told by patient. The end product of this interweaving of texts is a radically new, jointly authored story. Or as Hillman [1] explains it, the client comes to therapy to be "restored":

The patient is in search of a new story, or of reconnecting with her old one...The story needed to be doctored, not her. (pp. 17-18)

The specific therapeutic direction will depend on the nature of the problem. A loss of religious faith or conflict over spiritual values requires that the person begin to explore a new spiritual direction that is congruent with the person at this point in his/her development. Often with spiritual emergencies, the event itself has an inherently disjointed quality that has led therapists, patients, and society to devalue such experiences. Further exploration of such anomalous experiences is believed by many mental health professionals to be unnecessary and even to run the risk of exacerbating symptoms.

People who have had spiritual emergencies often do not receive validation for their experiences, or even the opportunity to talk about them. In the three case studies I have researched and published (Case Library), the hospital records did not mention any of the spiritual content present in these patients' episodes. The inpatient chart notes simply described them as delusional, having religious hallucinations, being preoccupied with space aliens, and making claims of having special powers. That information alone was sufficient to make the diagnosis of a psychotic disorder. In the medical model, further exploration of person's experiences would be unnecessary and could even exacerbate symptoms by reinforcing his/her "delusional system." Yet all three reported that working with me to put their story into writing was very helpful to them.

The conventional practice of discounting the meaning of spiritual emergencies is not therapeutically productive. The spiritual emergency itself isolates the individual from others. Then the subsequent devaluation and condemnation of the experience as "only the product of a diseased mind" results in further isolation, just when the person needs to reconnect to the social world. Thus, speaking one's story, putting the experience into words, is usually the first step in developing a life-affirming personal mythology that integrates the spiritual dimensions of the crisis.

At the turn of the century, Kurt Jaspers, MD, one of the founders of the nomenclature and methods used in understanding psychotic disorders, argued that there was an "abyss of difference" between psychosis and "normal" consciousness:

The profoundest difference in man's psychic life seems to exist between that type of psychic life which we can intuit and understand, and that type which, in its own way, is not understandable and which is truly distorted and schizophrenic...we cannot empathize, we cannot make them immediately understandable, although we try to grasp them somehow from the outside (Jaspers [2] p. 219).

Yet understandability is the result of a two-way interaction. Laing [3] has criticized the placing of responsibility totally on the patients for making their realities understandable to others.

"Both what you say and how I listen contribute to how close or far apart we are" (p. 38).

Work with spiritual emergency patients requires reaching across this abyss to connect with their reality.

One of the first objectives in narrative therapy is to find a mutually acceptable name for the problem. This is a continuation of the work in the acute phase to Normalize the experience (see Lesson 5). The term spiritual emergency appropriately describes and normalizes such crises. It provides a non pathological explanation for patients, family and friends to the rapidly developing literature on these types of problems, and it can become the basis for a new personal mythology.

It often helps to have the patient talk about and write out a full account of all they experienced. The word myth comes from the Greek mythos, meaning speech. I have found that simply constructing a time line marked with ages and key events serves a therapeutic ordering function. Then the work of Phases 2 and 3 can move more easily toward integrating the experience.

### **Phase 2: Tracing its Symbolic/Spiritual Heritage**

People in such crises do want their spiritual backgrounds and values to be taken into account. In my own spiritual emergency, I spent 2 months firmly convinced that I was a reincarnation of Buddha and Christ and was on a mission to write a new "Holy Book" that would unite all the peoples of the world. And I had been raised as a Jew! So, once I was back with both feet on my ground, this gave me great cause to explore these forms of spirituality with which I'd had minimal contact. In retrospect, I consider this period to be my spiritual awakening. But I could integrate it only after several years of therapy and work with traditional healers (See Self-Case Study Shamanic Crisis).

The treatment literature documents that there is much therapeutic value in addressing a person's religious delusions [4]. In cases where the person developed the grandiose delusion that they were God or the messiah, these stereotypical delusions of grandeur, inflation, and possibly inappropriate or demanding behavior could be embarrassing to the person. But the valid religious/spiritual dimensions of the experience can be salvaged through psychotherapy:

What remains . . . is an ideal model and a sense of direction which one can use to complete the transformation through his own purposeful methods (*Trials of the Visionary Mind: Spiritual Emergency and the Renewal Process*, by John Perry, MD, p. 38).

I now view my own experience of having been Buddha and Christ as the ideal models for my spiritual life, and this has given me a sense of direction. My career as a psychologist researching spiritual crises, and my spiritual path derive from that event.

James Hillman, Ph.D., [5] maintains that,

Recovery means recovering the divine from within the disorder, seeing that its contents are authentically religious (p. 10).

This recovery often involves helping patients reconcile their idiosyncratic personal symbols with parallels in symbolism and religious imagery. Eliade [6] pointed out that the personal unconscious and "private mythologies" (which are part of spiritual emergencies) cannot awaken an individual. It requires:

The general and the universal symbols [to] awaken individual experience and transmute it into a spiritual act, into metaphysical comprehension of the world (p. 213).

Much of my work in Jungian analysis consisted of learning how to explore the meaning of my personal symbols as they appeared in dreams and in my own spiritual emergency. This search for meaning by exploring parallels in traditional myths and religious texts has also played a role in the integration of many of the spiritual emergency patients with whom I have worked. I have documented this process in the case study *Myths in Mental Illness*.

### **Phase 3: Creating a New Personal Mythology**

People want more from therapy than a clear account and chronology (phase 1) and symbolic analysis (phase 2). They want an expanded and deepened sense of the meaning of their lives. Weaving the spiritual emergency into a life affirming personal mythology is essential for positive transformation and integration of the experience.

#### Personal Mythology (Definition)

Each of us has a personal mythology — beliefs about life that make up our view of the world. Stanley Krippner, Ph.D., co-author of *The Mythic Path: Discovering the Guiding Stories of Your Past — Creating A Vision for Your Future*, defines a personal mythology as an individual's system of complementary and contradictory personal myths. A personal myth is a cognitive-affective structure consisting of strongly ingrained beliefs with potent emotional components. Personal myths shape our expectations, and guide our decisions. They influence the way we behave with other people. They address life's most important concerns and questions, including

Identity--Who am I? Why am I here?

Direction--Where am I going? How do I get there?

Purpose--What am I doing here? Why am I going there? What does it all mean?

#### Personal Mythology in Psychotherapy

When people encounter religious and spiritual problems, they are usually dealing with the existential issues delineated as part of personal mythology. So they need to develop a more sustaining personal mythology for who they are at that moment. Unfortunately, with spiritual emergencies, many of the personal myths that people develop are

"dysfunctional." They emphasize pathological qualities and are not attuned to the person's actual needs, capacities, or circumstances.

The therapist's task is to help such patients develop a new personal mythology. This is a narrative approach to psychotherapy focusing on the shared retelling of the patient's story, reconstructing it for the patient's benefit.

Personal myths are developed using

biological sources--physical limitations, genetic endowments  
 cultural sources--economic and political systems, books, movies, folklore  
 personal history--family, romantic relationships, friendships, work

Spiritual sources often play a significant role in shaping personal mythologies. They can include nonconsensual reality experiences such as visions, past-life experiences, parapsychological experiences, and also spiritual emergencies. Such spiritual sources involve transcendence of ordinary life concerns and an experienced contact with a "higher" or "deeper" reality.

Spiritual emergencies often involve experiences of this type which can become the foundation for a new personal mythology. The therapist can help post spiritual emergency patients build a new personal mythology with spiritual sources drawn from their crisis.

For many people, recovery from a spiritual emergency is experienced as a spiritual journey, a personal myth. Sally Clay, who spent two years hospitalized and now works as a patient advocate, has written that,

For me, becoming "mentally ill" was always a spiritual crisis, and finding a spiritual model of recovery was a question of life or death (Clay [7]).

Not only are people who have had such a crisis challenged to compensate for weaknesses, but they are also invited to integrate their unique set of concerns, interests, temperament, and imagery, which may give clues to future vocational and avocational choices, social affiliations, and ideologies.

My own spiritual emergency set me on the path of becoming a "healer," and provided me with a vocational calling as a psychologist working with serious mental illness and with spiritual emergence. The Jungian analyst John Perry, MD, who developed Diabysis, an innovative treatment center for persons in an acute psychotic crisis, observed that,

It is also probable that those persons who come through their journey enriched and gifted may turn out to be the best source of congenial therapists, who would be able to react with unusual understanding to others going through their psychosis.  
 (*The Far Side of Madness*, p. 158).

Jeanne Achterberg, Ph.D., [8] also noticed the prevalence of "wounded healers" in the health professions.

The books, *The Mythic Path: Discovering the Guiding Stories of Your Past Creating-A Vision for Your Future* by David Feinstein, Ph.D. and Stanley Krippner, Ph.D., and *Your Mythic Journey: Finding Meaning in Your Life Through Writing and Storytelling* by Sam Keen, describe a variety of methods that facilitate the deepening of life-stories and the illumination of a person's personal mythology. It isn't always necessary for a person to work with a therapist to find the myth at the center of his/her life story.

However, the symbols encountered in spiritual emergencies are often idiosyncratic without a coherent cultural context. Jung noted that fragments of mythic themes and symbols occur frequently in the experiences of psychotic persons, but,

the associations are unsystematic, abrupt, grotesque, absurd and correspondingly difficult, if not impossible, to understand. They are further distorted by their chaotic randomness. (*Psychogenesis of Mental Disease*, pp. 262-263)

Therefore therapists are often helpful during the integration phase to help weave the images and symbols into a coherent personal mythology.

### References

- 1 Hillman, J. (1983). *Healing fiction*. New York: Station Hill Press.
- 2 Jaspers, K. (1963). *General psychopathology*. Manchester: Manchester Univ. Press.
- 3 Laing, R. D. (1982). *The voice of experience*. New York: Pantheon.
- 4 Eisenbruch M. (1992) Commentary: Toward a culturally sensitive DSM: Cultural bereavement in Cambodian refugees and the traditional healer as taxonomist. *J Nerv Ment Dis* 180(1): 8-10.
- 5 Hillman, J. (1986). On culture and chronic disorder. In R. Sardello and G. Thomas (Eds.), *Stirrings of culture*. Dallas: The Dallas Institute Publications.
- 6 Eliade, M. (1960). *Myths, dreams, and mysteries*. New York: Harper & Row.
- 7 Clay, S. (1987). Stigma and spirituality. *Journal of Contemplative Psychotherapy*, 4, 87-94.
- 8 Achterberg, J. (1988). The Wounded Healer. *Shaman's Drum*, 11, 18-22.

**REQUIRED QUIZ ITEM: 30****Psychotherapy**

People who have had a difficult period of spiritual emergence should be encouraged to move on with their lives and leave bizarre experiences behind.

true

false

Record your answer for later insertion into the Quiz.

## DSM-IV Religious and Spiritual Problems

### LESSON 7.1 Online Resources

**Sacred Texts • Case Example: Psychotherapy with a Muslim Immigrant • Case Example: Spiritual Crisis**

#### **Sacred Texts**

When patients present with religious issues, finding out more about their religion is essential. Information on religions and spiritual traditions around the globe and throughout history is readily available on the Internet. Almost all sacred texts are available online, often with commentary, for example,

rare Buddhist texts

the Bible (in many languages with commentary)

Even the Dead Sea Scrolls, which have not been fully translated, are available online for viewing.

The Internet Sacred Text Archive contains links to other texts.

<p><b>REQUIRED QUIZ ITEM 31</b></p>
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<p><b>Sacred Texts</b></p>
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<p>A sacred text for followers of Taosim is</p>
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<p>a) The Talmud b) Bhagavad Gita c) Qur'an d) Tao-te Ching</p>
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<p>Record your answer for later insertion into the Quiz.</p>
--

Media historians compare the online dissemination of sacred texts to the creation of the printing press. The first documents circulated were religious works, beginning with the Bible. This had a profound effect on religion that led to the Protestant Revolution and the ongoing development of many new religious movements. Many theorists believe "the Internet, with its boxes, cables, wires, and satellites, is a materialization of the spiritual connection that we already share with our fellow humans but have been given little cultural permission to notice and celebrate" (Hawes, 1995, p. 35). By making learning about others' faiths, the Internet helps people from diverse religions and spiritual paths understand the common ideas that bind them together. The Internet could play a major role in increasing religious tolerance, an effect that could have profound implications for world peace, since most conflicts seem to revolve around religious differences.

There are also many clinical resources online.

Psychiatric Case Conference: [When Religion and Therapy Interface \(Video\)](#) Jennifer Cyr, MD University of Nebraska Medical Center

Grand rounds presentation on therapy with a pregnant Catholic woman who believed God would punish her if she had an abortion, but went ahead with the abortion.

National Office of Post-Abortion Reconciliation and Healing  
Researchers and psychotherapeutic professionals providing post-abortion support services within secular and religious settings including Project Rachel.

Case Example: Psychotherapy with a Muslim immigrant

Preparing to Counsel Clients of Different Backgrounds  
Excerpted from: [Counseling: The Spiritual Dimension](#)  
Edited by Mary Thomas Burke, PhD and Judith G. Miranti, EdD Article author: Robert T. Georgia

Mohammed is a recent immigrant from Iraq. College-educated and employed as a computer analyst, he is torn between his adherence to Islam and a desire to "fit in" in his adapted society. He has conflicted feelings about sex, family responsibilities, career ambitions, and his sense of personal identity. He is experiencing a tremendous strain between his religion and his new social milieu. For a long time, he hesitated to see a counselor for fear of being misunderstood because of cultural differences. He is not yet convinced that he has made the right decision in doing so.

Dr. Georgia poses three questions for the therapist who is trying to be culturally sensitive, including:

Have I adequately explored and evaluated my own religious values and beliefs so that I can identify possible biases, presuppositions, limitations, doubts, and still open questions? What kinds of resistance or maneuvering might I bring to a relationship with such a client?  
How can I familiarize myself with Islam? Which literature should I review to gain a comprehensive, open-minded, nonjudgmental understanding of the religion, particularly its influence on human functioning?  
How can I experience Islam in practice so that I can develop a personal sense of the familial, social, and cultural dimensions and expressions of the religion?

**The Internet can be used to address these questions!**

**Online Resources on Islamic Religious Beliefs and Values**

**Islam-101**

An educational site on Islam, its way of life, civilization and culture. It includes an introductory course on Islam and presents Islamic views on contemporary issues.

**Online Course on Islam**

Covers beliefs about God and death, worship practices, and the Prophet Mohammed.

**Yahoo directory of sites on Islamic Beliefs and Practices****Muslim Youth**

A site on growing up in America--stories, poems, personal accounts, and message board for Muslim youth.

**Collection beautiful Islamic architecture**

A site to appreciate Islamic sensibilities

**Case Example: Spiritual Crisis**

An Internet Guided tour of web sites that provide resources for a person undergoing a spiritual crisis, which has elements of visionary, shamanic, and mystical experience types. Begin by reading the case history on which the tour is based. It describes my own experience which occurred in 1971.

Resources on Spiritual Crises  
Religious and Spiritual Issues  
Shamanism  
LSD and Religious Experiences  
Online and Self-Help Resources

**Resources on Spiritual Crises**

The Internet contains many resources on spiritual emergencies. Below are some interviews with experts on spiritual emergencies that provide clinical perspectives on the growthful potential of such crises.

**Visionary Experience or Psychosis?****Mental breakdown as a Healing Process**

John Perry, MD worked extensively with individuals in the midst of acute psychotic episodes at Diabysis, the residential treatment center he founded. These are two links to interviews where he presents a Jungian growth model for acute psychotic episodes.

**Spiritual Crisis**

Christina Grof, author of books on spiritual emergency and co-founder of the Spiritual Emergency Network, describes her own transformative spiritual crisis.

**Religious and Spiritual Issues**

Since in my personal experience, I had identified so strongly with Buddha and Christ, I selected sites to learn more about who these figures were, their life stories, their messages. Raised in a Jewish family, I knew little about them at the time of my experience. During my Jungian analysis, I learned to view Buddha and Christ as ideal models of my own inner self.

Tricycle.com: Buddhism Basics□

An introduction to Buddhism, including the life of the Buddha.

Frequently asked questions about the life and death of Jesus Christ

The answers are given from a traditional Christian perspective: Who was Jesus? What did he say about himself? What evidence is there to support what he said? How and why did Jesus actually die? Did he really rise from the dead?

C.G. Jung, Analytical Psychology, and Culture

Jung observed that patients in a psychotic state experience mythological and religious symbols. In my Jungian analysis, I learned to see the symbolic value of my own "hallucinations" and "delusions." This well-developed web site on Jungian Analytical Psychology includes full text articles by Jungian analysts, a glossary of Jungian terms, dissertation abstracts, links to other Jungian web sites, listings of programs in Jungian training, and Jungian publishers.

Shamanism

Working with shamans, reading about shamanism (particularly shamanic initiatory crises), and participating in neoshamanic groups played a key role in integrating my spiritual emergency. Below are some of the resources on shamanism that I found relevant to my own experience.

The Soul of Shamanism: Western Fantasies, Imaginal Realities

This interview with Daniel C. Noel, PhD, Professor of Religious Studies, explores the meaning and value of neoshamanic experiences. Shamanic practices provide a controlled way to access the ecstatic states of consciousness that I had first encountered in my spiritual emergency.

The Way of the Shaman

Interview with Michael Harner, PhD, author of several books, including *The Jivaro*, *Hallucinogens and Shamanism*, and *The Way of the Shaman*. Dr. Harner is a former professor of anthropology and is currently the director of the Center for Shamanic Studies, which teaches Westerners how to live and practice as shamanic healers.

WWW Library on Shamanism

This section of the library contains many online resources on shamanism.

LSD and Religious Experiences

My spiritual emergency was also an intense and disorienting mystical experience that served as my spiritual awakening. It was triggered by taking LSD for the first time.

Huston Smith, PhD, Professor Emeritus of Philosophy at MIT and author of numerous books on comparative religion, maintains that LSD-related religious experiences occur and are valid.

Given the right set and setting, the drugs can induce religious experiences indistinguishable from ones that occur spontaneously. Nor need set and setting be exceptional. The way the statistics are currently running, it looks as if from one-fourth to one-third of the general population will have religious experiences if they take the drugs under naturalistic conditions, meaning by this conditions in which the researcher supports the subject but doesn't try to influence the direction his experience will take. Among subjects who have strong religious inclinations to begin with, the proportion of those having religious experiences jumps to three-quarters. If they take them in settings which are religious, too, the ratio soars to nine out of ten.

Do Drugs Have Religious Import? by Huston Smith, Ph.D., *The Journal of Philosophy*, Vol. LXI, No. 18, September 17, 1964

#### The Psychedelic Library

The Internet has a number of web sites that address the relationship between LSD and religious experience. This site has several articles on psychedelic drugs and religious experience by Alan Watts, Walter Houston Clark, and others.

Yet adverse reactions to psychedelic drugs do occur. A literature review concluded that broadly speaking, there are two types of outcome:

Acute, short-lived reactions are often fairly benign, whereas chronic, unremitting courses carry a poor prognosis. Delayed, intermittent phenomena ("flashbacks") and LSD-precipitated functional disorders that usually respond to treatment appropriate for the non-psychedelic-precipitated illnesses they resemble, round out this temporal means of classification.

— Strassman RJ. Adverse reactions to psychedelic drugs. A review of the literature. *J Nerv Ment Dis* 1984 Oct;172(10):577-95.

#### A Critical Review of Theories and Research Concerning Lysergic Acid Diethylamide (LSD) and Mental Health, Chapter 2: Psychosis□

by David Abrahart. LSD has also been linked to triggering psychotic episodes which don't always have a positive outcome, as this MA thesis shows in summaries of studies on this issue.

#### **Online and Self-Help Resources**

Most people who have experienced a spiritual emergency want to find out more about the nature of these experiences and to learn about other people's spiritual emergencies. Below are web sites where anyone can post their experience, read about others, or request a referral for a therapist.

Spiritual Emergency Resource Center

A guide for clinicians and a self-help resource for people integrating a spiritual crisis. Several personal experiences are online, and people can post theirs in an online discussion forum.

#### Sacred Transformations

Personal stories of spiritual emergencies, visions, awakenings, and their effects.

#### Center for Psychological & Spiritual Health (CPSH)

Formerly The Spiritual Emergence Network (which began as the Spiritual Emergency Network). Now with a clinic and also an Information and Referral Service that offers support and resources for individuals experiencing difficulties with their spiritual growth (415) 575-6299.

#### Spiritual Emergence Service

A nonprofit Canadian society staffed by volunteers that offers information and referrals for people in psychospiritual crisis.

### REQUIRED QUESTION ITEMS 32-36

#### Online Clinical Resources

Marelene is a 21 year old woman who has been meditating intensively for the past 6 months 6-8 hours a day and doing yoga as well. She went on a 10-day water fast with the intention of reading the Tibetan Book of the Dead. Five days into the fast, she became convinced that she has been selected to be the mother of the next Dali Lama. She is hardly sleeping and is very grandiose. She is not a risk to herself or others. Her uncle, a physician in another state, has told her and her parents that she's in a manic episode and should be put on lithium. A psychologist they consulted said it sounded like a type of spiritual emergency known as a kundalini awakening which is associated with intensive meditative and spiritual practices. He suggested it should resolve on its own with proper support and guidance.

32 Find an online article on spiritual emergency

33 Find a site with diagnostic criteria for spiritual emergency

34 Find a site with online support (Search for kundalini)

35 Find a site with information on the Tibetan Book of the Dead

36 Find a site where Marelene could post an account of her experiences and interact with others who have had similar experiences.

Record the name of the site or paste in the URL address for later insertion into the Quiz.

## **DSM-IV Religious and Spiritual Problems**

### **LESSON 7.2 Searching Medline**

#### **Medline • PubMed • Related Articles Searches • Search Terms**

##### **Medline**

Medline is a very powerful tool for obtaining the latest diagnostic and treatment findings, and it is free and easy to use. Medline (MEDlars onLINE) is a computerized bibliographic database of citations to published healthcare journal articles maintained by the National Library of Medicine (NLM). The bibliographic database covers the fields of medicine, nursing, dentistry, veterinary medicine, the health care system, and the preclinical sciences. It contains bibliographic citations (e.g., authors, title, and journal reference) and author abstracts from over 3900 biomedical journals published in the United States and 70 foreign countries. Medline currently contains over 10 million records dating back to 1966. While medical information is available from many sources, such as magazine articles, books, and web sites, Medline is considered a very authoritative resource because most of the Medline journals use peer review to determine the scientific validity of articles.

##### **PubMed**

While Medline is available for free on at least 20 web sites, PubMed is the web interface designed by the National Library of Medicine (NLM) which maintains Medline. NLM designed PubMed for searching over the Internet. PubMed provides a variety of search modes. You can run a simple search by entering one search term in the query box, or you can construct complex search strategies using Boolean commands and a search menu interface.

Despite the enormity of the Medline database, it is easy to search. You will almost always be able to find what you want using simple search terms. In a couple of hours of practice and reading of the online PubMed Manuals, you can become a power user, taking advantage of MeSH index terms, field searches, and Boolean connectors. However, even as a search novice, you will be able to conduct effective searches.

##### **Related Articles Searches**

Citations in PubMed will have a [See Related Articles] link to the right of the author. Clicking on this link results in another search in Medline for articles which are most closely related to the original article. PubMed compares words from the Title and Abstract of each citation, as well as the MeSH headings assigned, using a powerful word-weighted algorithm. The Related Articles citation display is in rank order from most to least relevant. The citation you linked from is displayed first. This is a very powerful yet simple way to refine your search.

##### **Search Terms**

Religion is a major heading under humanities with many subcategories covering specific traditions, such as Buddhism Christianity and Islam.

Religion also includes overlapping areas such as

Religion and Medicine

Religion and Psychology.

Each of these has subheadings as well. For example, under Religion and Psychology, are Pastoral Care and Spirituality

View the Medline Religion Mesh Description

Other MeSH descriptors that are relevant to religious and spiritual problems include

Mind-Body and Relaxation Techniques which includes meditation

Spiritual Therapies which includes shamanism and yoga.

MeSH notes that the term Mental Healing is also relevant.

**REQUIRED QUEST ITEMS 37**

**MeSH**

The term mental healing in MeSH appears

a) under Spiritual Therapies b) under Mind-Body and Relaxation Techniques c) under both d) under neither

Record your answer for later insertion into the Quiz.

Using Mesh you can combine terms such as religion and conversion to hone searches

**REQUIRED QUEST ITEMS 38**

**Medline: Simple searching**

Conduct a search for articles on conversion on PubMed by just entering the word conversion. Note the number of articles is over 59,000!

Record the name of a non religious conversion article that was found for later insertion into the Quiz.

**REQUIRED QUEST ITEMS 39**

Medline: Combined searching

Conduct a search for articles on conversion on PubMed by first going to Religion and using the MeSH browser. Click ADD this term/subheadings to the Search using operator: AND

Then add conversion after where it says "Religion"[MESH]-- so the box contains "Religion"[MESH] conversion. Click PubMed Search

Record the name of a religious conversion article that was found for later insertion into the Quiz.

**CE Quiz Form for DSM-IV Religious & Spiritual Problems****First Name****Last Name****License Number****State**

**Type of License (MCEP for California psychologists is available by submitting the certificate of completion for APA CE and the MCEP Reporting Form)**

APA

California BBS

California BRN

**E-mail address****Phone number****THIS IS A SECURE FORM****Credit Card number****Exp Date (xx/xx)****QUIZ AND QUEST ITEMS**

INSTRUCTIONS: To obtain CE credit, complete these Quiz and Quest items. 70% correct on the quiz and quest items combined is required. If you have trouble accessing a site, skip that item and write in "inaccessible." Also fill out the course evaluation items. Suggestion: Print this form out and fill it in as you complete the lessons. You can then insert your

answers into this online form or mail or fax in the form.

**Internet Guided Learning**  
**1035 B St. Petaluma CA 94952**  
**fax (603) 316-6102**

**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

**QUIZ ITEM 2: \_\_\_\_\_ viewed religious beliefs as fantasies that prevent people from coming to terms with how things really are.**

C G Jung

Sigmund Freud

Albert Ellis

b and c

**QUIZ ITEM 3: Religious or Spiritual Problem is**

a type of neurosis

a type of psychosis

a proposed new category for the DSM-V

a new diagnostic category in the DSM-IV

**QUIZ ITEM 4: In the study Religious struggle as a predictor of mortality among medically ill elderly patients: a 2-year longitudinal study, the authors concluded that elderly ill men and women who experience a religious struggle with their illness appear to be at decreased risk of death.**

True

False

**QUIZ ITEM 5: 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**

getting a legal mandate to enforce treatment  
working within the patient's belief system  
using rational disputation techniques  
none of the above

**QUIZ ITEM 6: Religious problems can be related to**

changes in membership

intensification of beliefs

conversion

all of the above

**QUIZ ITEM 7: According to The Cult Threat: Real or Imagined, membership in New Religious Movements is mainly in odd retreat centers and country communes.**

True

False

**QUIZ ITEM 8: In Anemia and limping in a vegetarian adolescent, the adolescent on the vegan diet imposed by the cult was deficient in**

calcium

vitamin D

vitamin B12

all of the above

**QUIZ ITEM 9: According to the authors of Losing God, what factors confound spiritual aspects of cancer care?**

nebulous language

distrust

dogma

all of the above.

**QUIZ ITEM 10: Spiritual emergency is a term developed by C. G. Jung.**

True

False

**QUIZ ITEM 11: Assagioli first proposed that spiritual practices can be associated with psychological disturbance.**

True

False

**QUIZ ITEM 12: A feeling of communion with the divine occurs**

more often in mystical experiences

more often in psychosis

in both mystical experiences and psychosis

**QUIZ ITEM 13: Oxman et al. in The language of altered states found that illness themes are more characteristic of mystical experiences than schizophrenic episodes.**

True

False

**QUIZ ITEM 14: Which of the following types of spiritual problems is occurring more frequently due to advances in medical technology.**

UFO abduction

Kundalini

NDE

Psychic Experiences

**QUIZ ITEM 15: Intensive meditation practices can lead to feelings of depersonalization**

anxiety

disorientation

all of the above

**QUIZ ITEM 16: A person experiencing symptoms related to a spiritual practice should be told to continue their practice until the symptoms subside.**

True

False

**QUIZ ITEM 17: Psychic experiences are an indicator that a person is in the midst of a psychotic episode.**

True

False

**QUIZ ITEM 18: In therapy, a person's psychic experiences should be**

put on extinction

considered a spiritual experience

considered a delusion

investigated for what it means to the client

**QUIZ ITEM 19: Visionary experiences can include psychotic symptoms.**

True

False

**QUIZ ITEM 20: John Perry, MD, developed a treatment program that**

used high doses of neuroleptics

encouraged expression of the psychosis

focused on the spiritual dimensions

both b and c

**QUIZ ITEM 21: Shamanic crises occur**

to individuals in traditional cultures

to individuals in contemporary societies

both a and b

**QUIZ ITEM 22: UFO and Alien Encounter Experiences**

are confined to people in certain cults

are reported by millions of people

are always associated with psychopathology

**QUIZ ITEM 23: Possession occurs**

only to people in tribal cultures

only in ancient cultures such as Egypt

throughout history and around the world

rarely in contemporary societies

**QUIZ ITEM 24: People in possession states should be**

given antipsychotic medications

asked about their religious practices

treated as prophets of their religion

**QUIZ ITEM 25: Psychiatric patients are**

more religious than the general public

less religious than the general public

as religious as the general public

**QUIZ ITEM 26: Religious or Spiritual Problem cannot be assigned as an Axis I diagnosis along with an Axis I Disorder.**

True

False

**QUIZ ITEM 27: Hearing voices when no one is present is a sign of a spiritual emergency**

a symptom of a mental disorder

potentially a or b

**QUIZ ITEM 28: Meditation is always a good intervention for spiritual crises.**

True

False

**QUIZ ITEM 29: Medication is always contraindicated in spiritual crises.**

True

False

**QUIZ ITEM 30: People who have had a difficult period of spiritual emergence should be encouraged to move on with their lives and leave bizarre experiences behind.**

True

False

**QUIZ ITEM 31: A sacred text for followers of Taosim is**

The Talmud

Bhagavad Gita

Qur'an

Tao-te Ching

**QUIZ ITEM 32: Find an online article on spiritual emergency**

**QUIZ ITEM 33: Find a site with diagnostic criteria for spiritual emergency**

**QUIZ ITEM 34:** Find a site with online support (Search for kundalini)

**QUIZ ITEM 35:** Find a site with information on the *Tibetan Book of the Dead*

**QUIZ ITEM 36:** Find a site where Marelene could post an account of her experiences and interact with others who have had similar experiences.

**QUIZ ITEM 37:** The term mental healing in MeSH appears under Spiritual Therapies  
under Mind-Body and Relaxation Techniques  
under both  
under neither

**QUIZ ITEM 38:** Conduct a search for articles on conversion on PubMed by just entering the word conversion. Insert the name of a non religious conversion article.

**QUIZ ITEM 39:** Conduct a search for articles on conversion on PubMed by first going to Religion and using the MeSH browser. Click ADD this term/subheadings to the Search using operator: AND  
Then add conversion after where it says "Religion"[MESH]-- so the box contains "Religion"[MESH] conversion Record the name of a religious conversion article

## **COURSE EVALUATION QUESTIONS**

**Question 1: This course expanded my knowledge and skills.**

Agree    Somewhat Agree    Neutral    Somewhat Disagree  
Disagree

**Question 2: I am confident that I know diagnostic criteria for distinguishing a spiritual crisis from a mental disorder.**

Agree Somewhat Agree Neutral Somewhat  
Disagree Disagree

**Question 3: I am confident that I know some treatment approaches for religious and spiritual problems.**

Agree Somewhat Agree Neutral Somewhat  
Disagree Disagree

**Question 4: I am confident that I can find clinical resources on religious and spiritual problems on the Internet.**

Agree Somewhat Agree Neutral Somewhat  
Disagree Disagree

**Question 5: Material was relevant to my professional activities.**

Agree Somewhat Agree Neutral Somewhat  
Disagree Disagree

**Question 6: Course lessons were written and organized clearly.**

Agree Somewhat Agree Neutral Somewhat  
Disagree Disagree

**Question 7: The course was appropriately challenging.**

Agree Somewhat Agree Neutral Somewhat  
Disagree Disagree

**Question 8: The online course confusing and difficult to complete**

Agree Somewhat Agree Neutral Somewhat  
Disagree Disagree

**Question 9: How would you rate the overall value of this course?**

Excellent

Good

Fair

Poor

**Question 10: Difficulties or suggestions for change (optional)**