Working with Spiritual Issues

Growing evidence suggests that religion and spirituality have beneficial effects on health.[1] People use spirituality for healing of illness, psychological growth, and self-actualization. A variety of spiritual problems may arise spontaneously or during intense practice.[2,3] At the acute stage, the presentation of these conditions can resemble mental disorders, causing disruption in psychosocial functioning. If properly recognized and treated, these experiences can be integrated into the person's life and result in personal growth and healing. Pathological labeling or misdiagnosis may result in inappropriate treatment and thereby intensify distress. As various spiritual practices are rapidly gaining popularity worldwide, the incidence of spiritual problems seen in the treatment is likely to increase. The importance of understanding spiritual problems and of developing comprehensive and effective treatment approaches cannot be overemphasized.

In 1994, the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV*),[4] introduced a new V-code titled "Religious or Spiritual Problem," acknowledging that a category of distressing religious and spiritual experiences that are nonpathological. A religious or spiritual problem is not a mental disorder but is a condition that requires clinical attention. The 2000 text revision

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of *DSM-IV* (*DSM-IV-TR*)[5] provides only a general definition for spiritual problems: "... questioning of other spiritual values which may not necessarily be related to an organized church or religious institution." It includes only two religious problem examples: "... distressing experiences that involve loss or questioning of faith, and problems associated with conversion to a new faith.

In this article, we will provide a general overview of various religious or spiritual problems in the larger context of spiritual issues. We also will suggest guidelines for assessment and treatment.

TYPES OF SPIRITUAL ISSUES

Religion, Faith, Moral, Value, or Existential Issues

Religious problems occur frequently in treatment. Examples include distress related to loss or questioning of faith, conversion to a new religion or denomination, or existential and moral issues.[6,7] Many people facing life-threatening and terminal illnesses use religious coping mechanisms, while others experience loss or questioning of their faith.[8,9] Existential issues such as recovering a sense of meaning in life commonly arise in patients suffering from major illnesses, trauma, or substance abuse problems.[10,11] Indeed, the most common religious and spiritual issues addressed in the literature actually

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concern physical illnesses. On the other hand, religious experiences can be associated with psychopathology in clinical situations, involving demonic possession, scrupulosity (obsessive thoughts about sin), or involvement in new religious movements and cults.[6, 12, 13]

Anomalous Experiences

An anomalous experience is defined as one that deviates from the usually accepted explanations of reality.[14] The typology proposed by numerous experts varies but with considerable overlap. *Variety of Anomalous Experiences: Examining the Scientific Evidence*, published by the American Psychological Association, reviewed 10 varieties of anomalous experiences, including mystical experiences, near-death experiences, alien abduction experiences, and psi-related experiences (such as telepathy, clairvoyance, and precognition).[14]

These experiences overlap considerably with the eight types of spiritual problems proposed by Lukoff et al., whose typology was based on systematic literature searches[15,16] and a study that systematically searched for and coded articles in Medline on religious and spiritual issues.[17] These four types also were included in the ten forms of spiritual emergencies described by Grof.[2] Other types of spiritual problems included visionary experiences, psychic experiences, possession experiences, and meditation and spiritual practice-related experiences.[18] It is beyond the scope of this article to discuss each form at length. We will briefly describe two well-documented forms and refer interested readers to Grof,[2] Lukoff,[6,18] Turner,[10] and Cardena[14] for information on other types.

Overall, studies have found little relationship between anomalous experiences and psychopathology.[14] Indeed, many of these experiences have been associated with claims of positive life changes after the experience. The majority of these experiences do not cause disruption in psychological, social, or occupational functioning and do not involve mental health treatment. However, some individuals may develop psychological or interpersonal difficulties, such as fear of ridicule or rejection by others, a sense of isolation, and difficulties reconciling their experiences with previous beliefs, values, or lifestyle.[19,20] The severe form has been described as a spiritual emergency, when a person experiences distress severe enough to cause disruption in psychosocial and occupational functioning.[2]

The sequelae of anomalous experiences can involve intense emotions, visions, perceptional disturbances, unusual thought processes, tremors, and sensations of heat and energy.[2] Whereas some anomalous experiences can occur spontaneously without precipitants, some may be precipitated by a stressful life situation, such as physical illness or loss of a close relationship, or deep involvement in spiritual practices such as meditation, yoga, or prayer.

Mystical experiences. The definitions of mystical experience used in research and clinical publications vary considerably. Nevertheless, most scholars agree that a mystical experience diverges from ordinary conscious awareness and leaves a strong impression of having encountered a reality different from or higher than everyday reality.[21] Numerous surveys have found that 30% to 40% of the general population report having had mystical experiences in which they felt as though they were very close to a powerful spiritual force that lifted them out of themselves; the percentage has increased during the past 30 years.[21-23]

Mystical experiences typically last 1 to 3 hours and are ineffable in nature.[24] People frequently report that they sensed the unity of all things, timelessness and spacelessness, and loss of self. Visions, voices, telepathy, contact with the dead, a new sense of purpose, and exaltation also are commonly reported.[24,25] Research to date suggests that mystical experiences often correlate with better psychological functioning and may promote psychological healing and change.[21]

Near-death Experiences (NDEs). A number of well-documented case reports and several carefully conducted research studies have established NDE as a clearly identifiable phenomenon that may occur in patients who have been clinically dead and then resuscitated.[26-29] Despite virtual suppression of cerebral cortical activities, patients report a continuity of subjective experience, including leaving the body, observing hospital events, passing through a dark tunnel, experiencing a bright light, and meeting spiritual beings. It has been estimated that about 5% to 30% of those who come close to death undergo a near-death experience.[28,29] Studies have consistently shown that NDEs are associated with positive and

CME EDUCATIONAL OBJECTIVES

1. Describe some of the spiritual issues seen in clinical situations.
2. Suggest guidelines for assessing and diagnosing spiritual problems.
3. Discuss therapeutic strategies for working with people with spiritual issues.

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long-lasting effects, including a more empathic attitude, more involvement with family, a greater sense of life purpose and meaning, more interest in spirituality, less fear of death, a stronger belief in an afterlife, and a greater appreciation for ordinary things.[26-29]

Issues Concurrent With Mental Disorders

Psychiatric disorders can include distressing spiritual experiences. For example, people with major depressive disorder may develop mood-congruent delusions, such as being controlled by the devil or punished by God. People in the manic phases of bipolar disorder or schizoaffective disorder may believe that they are Jesus Christ or have divine missions to fulfill. In addition, patients with substance abuse disorders may have hallucinations, such as seeing angels or hearing voices from God. Many people with mental disorders have distressing spiritual experiences and beliefs that become a focus of treatment. This should be noted by assigning an additional diagnosis of religious or spiritual problem.

On the other hand, spiritual problems may coexist with or contribute to psychopathology, as illustrated by the following case vignette.[19] Mr. V had an NDE at age 14, when he was climbing a tree and electrocuted by an overhead power line. While he was being resuscitated, he felt he was in communication with both his deceased grandfather and Christ. After the experience, he believed that he was saved by Christ and sent back to life with a mission to complete. He began to question the value of his routine activities as a high school student, a guitarist in a rock band, and a quarterback on football team. He felt confused because he was unable to reconcile his new sense of importance and the purpose with his daily life. He was not able to talk with others about his experiences and felt estranged from peers. He continued to experience flashbacks and nightmares of the accident. He became depressed and began to abuse alcohol and cocaine. In addition to a posttraumatic stress disorder, a major depressive disorder, and a substance abuse disorder, Mr. V was given a concurrent diagnosis of a religious or spiritual problem.

SIDEBAR.

Criteria Favoring the Diagnosis of a Spiritual Problem[24]

A. All of the following criteria must be present:

1. Ecstatic mood, a sense of exultation, or immense joyousness.
2. Sense of newly gained knowledge into depths of truth.
3. Perceptual alterations ranging from heightened sensations to auditory and visual hallucinations.
4. Delusions (if present) have themes related to mythology.
5. No conceptual disorganization as evidenced by disruption in thought, incoherence and blocking.

B. At least two of the following four positive outcome predictors must be present:

1. Good pre-episode functioning.
2. Acute onset of symptoms during a period of 3 months or less.
3. Phenomena usually follow stressful precipitants.
4. Positive exploratory attitude toward the experience.

ASSESSING SPIRITUAL PROBLEMS

Clinicians should globally assess patients' religious and spiritual upbringing, current religious affiliation, spiritual practices, and beliefs. They also should seek to understand whether their patients' religiosity or spirituality in some way intertwines with or contributes to problems and disturbances. They should attempt to determine whether their patients have religious or spiritual resources that could be used in therapy to help promote coping, healing, and change.[7,12]

While some spiritual experiences may induce distress, most do not require psychiatric diagnosis or intervention. If the distress becomes severe enough to warrant clinical attention, it should be added to the patient's multimodal diagnosis as a V-code, or religious and spiritual problem, in *DSM-IV-TR*. V-code categories are to be coded on Axis I. They can be assigned along with a co-existing Axis I mental disorder.

The presentation of some spiritual problems can, in the most intense types, resemble that of a psychotic disorder. Criteria for differentiating spiritual problems from mental disorders have been proposed by many authors, with considerable overlap.[2,24,30] An extensive literature review of the research on mystical experiences and on the outcomes from psychotic episodes proposed several criteria favoring the diagnosis of a spiritual problem, outlined in the Sidebar.[24]

CASE EXAMPLE

Mr. C was an 18- year-old bilingual Vietnamese American man who was brought to the hospital by his family because of recent bizarre behavior. He was physically healthy and had no history of mental illness or substance abuse. He grew up in a devout Catholic family who immigrated to America when he was 11 years old. Two months prior to admission, he broke up his girlfriend of 2 years. Since then, he had spent most of his day praying and reading religious books. He began to hear voices talking about good and evil. Two days prior to admission, he walked around the neighborhood barefoot, putting religious labels on people's doors. He spread dirt

ing support. He started to take risperidone with the family's encouragement, at a lower dose of 0.5 mg at bedtime. He was advised to pay attention to his physical sensations, such as touching, and to observe the environment rather than to his inner world.

In the subsequent 3 days, his sense of reality continued to improve. He realized that the voices he was hearing were actually his own thoughts. Instead of claiming that he could read people's minds, he realized that he could only interpret people based on their body language. He claimed that this experience made him a more loving person. He expressed his wish to attend college so that he could become a priest and help others. He was discharged to home on the seventh hospital day. He chose not to follow up with psychiatric outpatient services but agreed to meet with his church priest regularly.

Studies have consistently shown that near-death experiences are associated with positive and long-lasting effects, including a more empathic attitude, more involvement with family, a greater sense of life purpose and meaning, and less fear of death.

on his mattress and slept on it naked. He revealed that was hearing voices of good and evil and that he could read minds of people and animals.

He was isolative and mute upon admission to the inpatient ward. He sat on the floor cross-legged in the lotus position, meditating. At other times, he lay on the floor naked with a piece of cloth wrapped around his groin. To target his psychotic symptoms, he was prescribed risperidone at a dose of 1 mg twice per day, but he refused to take any medication. He was allowed to stay in his room alone without disruption.

As he became more communicative 3 days later, he explained that he had read a book describing how Jesus and his disciples lived their lives. He imitated them by dressing and behaving like them. By sleeping on dirt, he found that he could be close to animals, to love them. He claimed that he was able to see good and evil through people's eyes. He admitted that he had been confused and out of touch with reality during the past few days but denied that he was feeling depressed.

The treatment team considered the diagnosis of a spiritual emergency. Family meetings were held to educate them about his condition and ways to provide ongo-

THERAPEUTIC APPROACHES

Spiritual beliefs and feelings are usually private and held to be sacred. Therefore, establishing a trusting relationship and working alliance is crucial in exploring religious and spiritual issues. West[31] suggested several features that help to build a spiritually open and safe alliance in psychotherapy. These features include accepting that therapy can be a spiritual space; tolerating silence and not using techniques so that the spiritual space can enfold; "listening" in a deep and holistic manner to words, feelings, and spiritual impressions; speaking authentically by appropriately sharing feelings of the heart; and accepting the spiritual experiences that occur.

Working With Religious, Faith, Moral, Value, or Existential Issues

The American Psychiatric Association Committee on Religion and Psychiatry recommends that psychiatrists maintain empathic respect for patients' beliefs and not impose their beliefs on patients.[32] Many authors suggest that clinicians need to adopt a respectful attitude toward clients of diverse religious backgrounds. They need to be aware of their own spiritual heritage and values and understand how their own spiritual beliefs could bias their clinical judgment. They should elicit background information about their patients' religious beliefs and encourage them to draw strength from their spiritual resources.[6,12,33] They should seek to increase their knowledge and empathy for other spiritual traditions and beliefs and tailor therapeutic approaches to patient based on this knowledge.[12] Interested readers are referred to two excellent books that address religious issues in therapy, *Spiritually Oriented Psychotherapy* by Sperry and Shafranske and the *Handbook of Psychotherapy and Religious Diversity* by Richards and Bergin.[34,35]

Some theistic therapists hold that there are moral absolutes that promote health and welfare and that it is ethical to convey and endorse healthy moral values.[36] However, the clinician's primary goal is to promote patients' self-determination and not to be a "missionary" for a particular value. The clinician should respect patients' values, regardless of whether they are healthy or unhealthy, and help them find their own sources of strength and meaning. Clinicians may

convey healthy values respectfully and allow the person to exercise autonomy and bear consequences.[12,37]

Working With Anomalous Experiences

Griffith[33] discussed a number of attitudes and skills that may be helpful in shaping therapeutic dialogues to include spiritual experiences. They include fostering an attitude of curiosity and wonder by attenuating cynicism and certainty; cultivating a climate of openness and respect, allowing flexibility in the structure of the therapy; paying attention to feelings and bodily sensations so that spiritual experiences can be recognized, understood, and expressed; and carefully listening to what clients speak about spontaneously.

In working with anomalous experiences, the role of the clinician is to support and strengthen the patient, without judgment. Clinicians should normalize the experience when appropriate. Rather than trying to determine whether the experiences actually occurred or are "real," clinicians should focus on assessing how the patient interprets the experience. Clinicians may help the patients explore the meaning of the experience and encourage him or her to use it for growth and change.[38,39]

The extent of assistance required for spiritual emergencies varies according to the intensity of the experience.[2,3] For milder forms, providing a safe and supportive environment may be sufficient. The compassionate presence of a therapist and the understanding of supportive people among relatives offer a nurturing environment for the healing process to take place. Educating the patient about the growth potential and time-limited nature of the process can help to reduce distress. Family and important friends should be included in the support network and offered as much information about the situation as possible.

If the problem seriously interferes with everyday functioning, more specific therapeutic measures should be undertaken. Grounding, centering, and catharsis are important therapeutic steps to facilitate healing. Patients should be encouraged to express their experiences through expressive work such as sand tray, music, dance, drawing, or writing. They should be encouraged to explore the symbolic meaning of their experiences. Grounding can be facilitated by being mindful of body sensations, taking a walk in nature, working with plants in the garden, connecting to people in a support group, or eating meat or dairy products.

Working with spiritual emergencies frequently requires expertise from various disciplines. When appropriate, clinicians should collaborate with spiritually oriented therapists or pastoral counselors, or refer patients to a spiritual support group.

A person who has experienced a spiritual emergency should be monitored closely for self-destructive behavior, disorientation, or fearfulness. Inpatient hospitalization might be needed if the person were to become at risk of posing a danger to self or others. Most of the psychotropic medications can stop the natural enfolding process by dulling inner awareness and preventing a potentially therapeutic catharsis. Minimizing the use of medications allows the patient to be observed in his or her more natural state for accurate assessment. Low doses of minor tranquilizers may be indicated in situations where slowing down the process is necessary to prevent harm.[2]

Working With Issues Concurrent With Mental Disorders

Addressing the religious and spiritual beliefs and experiences of a patient with a psychotic disorder can have therapeutic benefit. Particularly during the post-acute phase, clinicians may help patients explore the spiritual contents of their hallucinations and delusions to find personal insights and archetypal patterns that have growth potential.[40] In addition, spirituality has been incorporated as a core element in the recovery movement. Research has shown that a patient's spirituality can play an important role in ameliorating the distress and problems of severe illness, including mental disorders.[1]

SUMMARY

Clinicians increasingly acknowledge that they need to take patients' spiritual lives and experiences into account, yet few have been trained in assessing or working with spiritual issues. The importance of understanding religious and spiritual problems and of developing effective treatment approaches is recog-

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nized as a core competency of psychiatric practice.[41] The Joint Commission on Accreditation of Heathcare Organizations mandates the routine assessment of spiritual needs and that the spiritual component of a person's life be considered in healthcare.[42] Explicit and nonjudgmental attention to religious and spiritual concerns can add significantly to the quality and effectiveness of clinical work. In addition, clinicians should familiarize themselves with literature on various spiritual problems and therapeutic approaches. They may also choose to adopt individual spiritual practices or undergo spiritually oriented psychotherapy. Such experiences are likely to foster cultural sensitivity to spiritual issues and enhance competence in guiding patients and families through their experiences.

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