From Spiritual Emergency to Spiritual Problem: *The Transpersonal Roots of the New DSM-IV Category*

by David Lukoff, PhD

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Abstract

Religious or Spiritual Problem is a new diagnostic category (Code V62.89) in the Diagnostic and Statistical Manual-Fourth Edition (APA, 1994). While the acceptance of this new category was based on a proposal documenting the extensive literature on the frequent occurrence of religious and spiritual issues in clinical practice, the impetus for the proposal came from transpersonal clinicians whose initial focus was on spiritual emergencies--forms of distress associated with spiritual practices and experiences. The proposal grew out of the work of the Spiritual Emergence Network to increase the competence of mental health professionals in sensitivity to such spiritual issues. This article describes the rationale for this new category, the history of the proposal, transpersonal perspectives on spiritual emergency, types of religious and spiritual problems (with case illustrations), differential diagnostic issues, psychotherapeutic approaches, and the likely increase in number of persons seeking therapy for spiritual problems. It also presents the preliminary findings from a database of religious and spiritual problems.

Introduction

"Religious or Spiritual Problem" is a new diagnostic category (Code V62.89) in the Diagnostic and Statistical Manual-Fourth Edition (APA, 1994). The Thesaurus of Psychological Index Terms (Walker, 1991) states that religiosity "is associated with religious organizations and religious personnel" (p. 184) whereas spirituality refers to the "degree of involvement or state of awareness or devotion to a higher being or life philosophy. Not always related to conventional religious beliefs" (p. 208). Thus religious problems involve a person's conflicts over the beliefs, practices, rituals and experiences related to a religious institution. Some forms of spirituality presume no external divine or transcendent forces (e.g.,

humanistic-phenomenological spirituality) (Elkins, Hedstrom, Hughes, Leaf, and Saunders,1988), and spiritual problems involve distress associated with a person's relationship to a higher power or transcendent force that is not related to a religious organization.

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Rationale For A New Diagnostic Category

Prevalence of Religious and Spiritual Problems

In a survey of APA member psychologists, 60% reported that clients often expressed their personal experiences in religious language, and that at least 1 in 6 of their patients presented issues which directly involve religion or spirituality (Shafranske & Maloney, 1990). Another study of psychologists found 72% indicating that they had at some time addressed religious or spiritual issues in treatment (Lannert, 1991). In a sample that included psychologists, psychiatrists, social workers, and marriage and family therapists, 29% agreed that religious issues are important in the treatment of all or many of their clients (Bergin & Jensen, 1990). Anderson and Young (1988) claim that: "All clinicians inevitably face the challenge of treating patients with religious troubles and preoccupations" (p. 532). While little is known about the prevalence of specific types of religious and spiritual problems in treatment, these surveys demonstrate that religious and spiritual issues are often addressed in psychotherapy.

Lack of Training in Religious and Spiritual Issues

In a survey of Association of Psychology Internship Centers training directors, 83% reported that discussions of religious and spiritual issues in training occurred rarely or never. One hundred per cent indicated they had received no education or training in religious or spiritual issues during their formal internship. Most of the training directors did not read professional literature addressing religious and spiritual issues in treatment, and they stated that little was being done at their internship sites to address these issues in clinical training (Lannert, 1991). A national study of APA member psychologists found that 85% reported rarely or never having discussed religion and spiritual issues during their own training (Shafranske & Maloney, 1990). Similar findings from other surveys suggest that this lack of training is the norm throughout the mental health professions (Sansone, Khatain & Rodenhauser, 1990).

Ethical Mandate To Provide Training

According to the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 1992), psychologists have an ethical responsibility to be aware of

social and cultural factors which may affect assessment and treatment (Canter, Bennet, Jones & Nagy, 1994). Since the religious and spiritual dimensions of culture are among the most important factors that structure human experience, beliefs, values, behavior as well as illness patterns (James, 1958; Krippner & Welch, 1992), sensitivity to religious and spiritual issues is an important part of the cultural diversity competence of psychologists. Certain issues in differential diagnosis require knowledge of the patient's religious subgroup (Lovinger, 1984) and/or the nature of acceptable expressions of subculturally validated forms of religious expression. For example, discussing one of the cases in the DSM-III-R Casebook, Spitzer, Gibbon & Skodol (1989) noted that, "The central question in the differential diagnosis in this case is whether or not the visions, voices, unusual beliefs, and bizarre behavior are symptoms of a true psychotic disorder...[or] Can this woman's unusual perceptual experiences and strange notions be entirely accounted for by her religious beliefs?" (pp. 245-6). Similarly, distinguishing between a spiritual problem and psychopathology requires knowledge about spiritual beliefs, practices and their effects (Lukoff, 1985).

In the training of psychiatrists, such preparation is now required by the Accreditation Council for Graduate Medical Education. Their "Special Requirements for Residency Training in Psychiatry" published in 1995 mandates instruction about gender, ethnicity, sexual orientation, and religious/spiritual beliefs in accredited residency training programs. Psychologists are also required to be aware of their need for training (Canter et al., 1994). Unfortunately, the current APA accreditation guidelines for graduate training programs and internships do not directly address competency in addressing religious and spiritual diversity, despite indications that the training of psychologists is inadequate in this area (Lannert, 1991).

Psychologists are also required to provide services only within their boundaries of competence (Canter et al., 1994). The surveys reviewed above show that psychologists are very likely to work with the religious and spiritual issues of their clients. Yet their lack of training in the assessment and treatment of religious and spiritual problems may lead to insensitivity and/or counter-transference issues that interfere with their ability to understand and explore their clients' issues. (Meyer, 1988; Shafranske & Gorsuch, 1984; Strommen, 1984)). In addition, there are unique ethical issues involved in working with spiritual problems, especially those that involve altered states of consciousness (Taylor, 1995). Ignorance, countertransference, and lack of skill can impede the untrained psychologist's ethical provision of therapeutic services to clients who present with spiritual problems.

History of the Proposal for Religious or Spiritual Problem

The initial impetus for this proposal came from the Spiritual Emergence Network (then called the Spiritual Emergency Network) which was concerned with the mental health system's pathologizing approach to intense spiritual crises. The auhtors decided to propose a new diagnostic category for the then-in-development DSM-IV as the most effective way to increase the sensitivity fo mental health professionals to spiritual issues in therapy. A previous article in the Journal of Transpersonal Psychology (Lukoff, 1985) had proposed a new diagnostic category entitled Mystical Experience with Psychotic Features (MEPF) for intense spiritual experiences that present as psychotic-like episodes. An analogy was drawn between MEPF and the DSM-III-R category of Uncomplicated Bereavement, which is a V Code--a condition *not attributable to a mental disorder*. The definition for this category notes that even when the period of bereavement following a significant loss meets the diagnostic criteria for Major Depression, this diagnosis is not given because the symptoms result from "a normal reaction to the death of a loved one" (p. 361). Similarly, individuals in the midst of a

tumultuous spiritual experience (a "spiritual emergency") may appear to have a mental disorder if viewed out of context, but are actually undergoing a "normal reaction" which warrants a non-pathological diagnosis (i.e., a V Code for a condition not attributable to a mental disorder) (Lukoff, 1988a).

Following this precedent of bereavement in DSM-III-R of a nonpathological category for a distressing and disruptive experience, we notified the American Psychiatric Association's Task Force on DSM-IV in early 1991 of our intention to submit a propoosal for a new V Code category entitled "Psychospiritual Conflict." We contacted other experts in the field, including several members of APA's Division 36 (Psychology of Religion), to obtain their support and suggestions for relevant research and case studies. We also conducted several literature searches on PsychINFO, Medline and Religion Index to obtain references to clinical and research literature (Lukoff, Turner & Lu, 1992; Lukoff, Turner & Lu, 1993). At the 1991 and 1992 Association for Transpersonal Psychology Conferences, we presented our ideas for the new category and received useful suggestions from other transpersonally-oriented psychologists and psychiatrists.

As the proposal evolved, we substituted "problem" for "conflict" to be more in line with the terminology employed in the V Code section of DSM-III-R (e.g., Parent-Child Problem, Phase of Life Problem). To obtain greater support for the proposal and to acknowledge the many areas of overlap between spirituality and religion, we expanded our proposal to include both psychospiritual and psychoreligious problems. The literature review established the most prevalent and clinically significant problems within each category, enabling us to arrive at the following definition for a proposed V Code:

Psychoreligious problems are experiences that a person finds troubling or distressing and that involve the beliefs and practices of an organized church or religious institution. Examples include loss or questioning of a firmly held faith, change in denominational membership, conversion to a new faith, and intensification of adherence to religious practices and orthodoxy. Psychospiritual problems are experiences that a person finds troubling or distressing and that involve that person's relationship with a transcendent being or force. These problems are not necessarily related to the beliefs and practices of an organized church or religious institution. Examples include near-death experience and mystical experience. This category can be used when the focus of treatment or diagnosis is a psychoreligious or psychospiritual problem that is not attributable to a mental disorder.

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 since this was one of the priorities established for the revision (Frances, First, Widiger, Miele, Tilly, David, & Pincus, 1991), and also argued that the adoption of this new category would result in the following benefits: 1) increasing the accuracy of diagnostic assessments when religious and spiritual issues are involved; 2) reducing the occurrence of iatrogenic harm from misdiagnosis of religious and spiritual problems; 3) improving treatment of such problems by stimulating clinical research; and 4) 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 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:

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 (Steinfels, 1994), San Francisco Chronicle (Lattin, 1994), Psychiatric News (McIntyre, 1994), and the APA Monitor (Sleek, 1994) where it was described as indicating an important shift in the mental health profession's stance toward religion and spirituality. What did not receive attention in the media is that this new diagnostic category has its roots in the transpersonal movement's attention to spiritual emergencies.

Transpersonal Perspectives on Spiritual Emergency

Assagioli (1989), in his seminal paper, "Self-Realization and Psychological Disturbances," noted the association between spiritual practices and psychological problems. For example, 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). Stanislav and Christina Grof coined the term "spiritual emergency" and founded the Spiritual Emergency Network (Prevatt & Park, 1989) in 1980 to identify a variety of psychological difficulties, particularly those associated with Asian spiritual practices that entered the West starting in the 1960's. They define spiritual emergencies as:
crises when the process of growth and change becomes chaotic and overwhelming. Individuals experiencing such episodes may feel that their sense of identity is breaking down, that their old values no longer hold true, and that the very ground beneath their personal realities is radically shifting. In many cases, new realms of mystical and spiritual experience enter their lives suddenly and dramatically, resulting in fear and confusion. They may feel tremendous anxiety, have difficulty coping with their daily lives, jobs, and relationships, and may even fear for their own sanity (Grof & Grof, 1989, back cover)

Grof and Grof (1989) note that "Episodes of this kind have been described in sacred literature of all ages as a result of meditative practices and as signposts of the mystical path" (p. x). They have described the more common presentations including: mystical experiences, kundalini awakening (a complex physio-psychospiritual transformative process observed in the Yogic tradition) (Greenwell, 1990), shamanistic initiatory crisis (a rite of passage for shamans-to-be in indigenous cultures, commonly involving physical illness and/or psychological crisis) (Lukoff, 1991; Silverman, 1967), possession states (Lukoff, 1993) and psychic opening (the sudden occurrence of paranormal experiences) (Armstrong, 1989). Their list of types has expanded from an initial typology of 8 to currently some 12 types, although in actual clinical practice there is often overlap between these types. A distinguishing characteristic of spiritual emergencies is that despite the distress, they can have very beneficial transformative effects on individuals who experience them. Several types of spiritual emergency are illustrated below. The diagnostic formulation of Psychospiritual

Conflict in the initial development of the proposal for a new category was specifically intended to be inclusive of persons undergoing spiritual emergencies.

Case Study Database on Religious and Spiritual Problems

While there is limited psychological theory that is useful in understanding spiritual problems, there is an extensive knowledgebase that has developed at the case level. Kazdin (1982) has observed that, "Although each case is studied individually, the information is accumulated to identify more general relationships" (p. 8). Bromley (1986) likens this to the building up of case-law in jurisprudence, which

provides rules, generalizations and categories which gradually systematize the knowledge (facts and theories) gained from the intensive study of individual cases. Case-law (theory, in effect) emerges through a process of conceptual refinement as successive cases are considered in relation to each other. (p.2)

Despite the disrepute in which case studies are generally held (i.e., case study methods are rarely taught in the research methods courses in graduate psychology programs), they are still a primary mode of transmitting knowledge (Hunter, 1986). Grand rounds and intake presentations are two institutionalized forms by which health professionals disseminate the latest understandings and make links between the generalized abstractions of diagnostic categories and a particular patient. In addition, case studies play a significant role in advancing knowledge by focusing on anomalies that highlight inadequacies in understanding, diagnosis and treatment (Churchill & Churchill, 1982). Case study findings have played a pivotal role in the evolution of academic psychology and particularly psychotherapy (Edwards, 1991; Kazdin, 1982). In transpersonal psychology (Boorstein, 1980; Chinen, 1988; Lukoff, 1988b) and humanistic psychology (Bugental, 1990; Schneider & May, 1995; Yalom, 1989) as well, published case studies have guided the development of assessment and therapeutic approaches.

Cases where a focus of therapy involves a religious or spiritual problem are not very easy to find. A systematic analysis of case reports involving religious or spiritual issues the Medline bibliographic database from 1980-1996 located only 364 abstracts which addressed religious or spiritual issues in health care. This was from a database containing 4,306,906 records from this period (Glazer, National Library of Medicine, personal communication, May 1997), indicating that a shockingly low.008% of published articles in the major medical health care database address religious and spiritual issues. Through multiple searches on PsycINFO and Medline, over 100 cases that describe religious and spiritual problems have been located (Lukoff et al., 1992; Lukoff et al., 1993). No claim is made that the numbers of cases in the database shown in table 1 are representative of the prevalence of cases seen in clinical practice. They are probably more indicative of the types of problems that mental health professionals like to write about. In addition, the quality of the case reports varies widely. Few use any checks for reliability or validity (Yin, 1993). But as Bugental (1995) has noted:

Writing about the work of psychotherapy is challenging, apt to slide into oversimplification, difficult to keep to a consistent level of specificity or abstraction, and vulnerable to manipulation. Nevertheless, it is important to bring the experiences of our consultation rooms into our literature and to attempt to convey the uncommunicable, the subtle interplay between two human beings trying to work with and improve the life experience of one (or both?) of them. (p. 102)

Table 1. Numbers of Cases in Database by Type

Number	Type
Religious Problems	
4	Change in denomination/Conversion
5	Intensification of religious belief or practice
12	Loss of faith
5	Joining or leaving a New Religious Movement or cult
5	Other religious problem
Spiritual Problems	
2	Loss of faith
4	Near-death experience
2	Mystical experience
3	Kundalini
4	Shamanistic Initiatory Crisis
2	Psychic opening
2	Past lives
2	Possession
4	Meditation-related
2	Separating from a spiritual teacher
2	Other spiritual problem
Combined Religious/Spiritual Problem	
17	Serious illness
6	Terminal illness
Overlap of Religious/Spiritual Problem and DSM-IV Disorder	
2	Religious/spiritual problem concurrent with substance abuse
7	Religious/spiritual problem concurrent with psychotic disorder
2	Religious/spiritual problem concurrent with mood disorder
1	Religious/spiritual problem concurrent with dissociative disorder
1	Religious/spiritual problem concurrent with obsessive-compulsive disorder

Types of Religious Problems

The most common examples of religious problems described in the clinical literature include loss or questioning of faith, change in denominational membership or conversion to a new religion, intensification of adherence to the beliefs and practices of one's own faith, and joining, participating or leaving a new religious movement or cult. Usually people undergo such changes without any significant psychological difficulty, but the clinical literature documents cases of individuals who experience significant distress and seek mental health assessment and treatment for these problems. Discussions and clinical examples of religious problems can be found in Lukoff et al. (1992), Lukoff, Lu & Turner (1995), and Turner, Lukoff, Barnhouse & Lu (1985). This article focuses on types of spiritual problems, including spiritual emergencies, that have been identified, particularly in the literature in transpersonal

psychology. Below summaries of published case studies are used to illustrate the key differential diagnostic and treatment issues involved in several types of spiritual problems.

Types of Spiritual Problems

Questioning of Spiritual Values The DSM-IV definition notes that spiritual problems may be related to questioning of spiritual values. In the clinical literature, many cases which involve a questioning of spiritual values are triggered by an experience of loss of a sense of spiritual connection. Barra, Carlson and Maize (1993) 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 or spiritual 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 [or spiritual] tenets and community identification. (p. 292)

Loss of faith is mentioned in the DSM-IV definition as a religious problem, but as Barra et al. (1993) note, the same sequalae can result from the loss of spiritual connection. One case which involved questioning of spiritual values was described by Emma Bragdon (1994).

In 1971, Emma's mother, then 56 was living alone in a small town Vermont, and working as a visiting nurse. She was a Zen Buddhist practicing meditation 6-8 hours daily. Her friends noticed that she was spending more time alone and was becoming increasingly emotionally labile. They contacted Emma, but she did not sense a problem since she was having cheerful talks on the telephone with her mother about plans for her mother to visit during the birth of Emma's first child. However, before this happened, Emma's mother went into the woods alone, reading a passage from Zen Mind, Beginner's Mind where Suzuki Roshi compares enlightenment to physical death. When found dead, her finger was pointing to this passage. She had cut her wrists and throat.

In addition to the bereavement over her mother's suicide, this loss also triggered a spiritual problem for Emma who was herself a practicing Zen Buddhist. How could her spiritual path lead to her mother's suicide? Emma contacted Suzuki Roshi, who flew with her to Vermont where he conducted a traditional Buddhist funeral ceremony. During this time, Emma had a number of powerful spiritual experiences, including feeling herself engulfed in white light accompanied by ecstatic release. She sensed that her mother was fine, and that her passing had been a happy occasion for her. But afterwards, when back in California, she began to have doubts. How did she really know her mother was OK? As she became preoccupied with questioning the validity of her spiritual experiences and tenets, she also wondered if she was crazy. When it was 10 days past her due date, she went into her garden to pray, and made a commitment to stop questioning her spiritual beliefs until 2 months after giving birth. One hour later, she reports she went into labor. (adapted from pp. 171-177)

During this period, Emma was in turmoil as she questioned her spiritual beliefs and path. The guidance of a spiritual teacher, Suzuki Roshi, and spiritual practices, such as praying, played an important role in helping her to resolve these conflicts.

Meditation-related Problems

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). Epstein (1990) 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 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 (Bogart, 1991; Walsh & Roche, 1979). Yet Walsh and Roche (1979) 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).

Kornfield (1993), a psychologist and experienced meditation teacher, described what he termed a spiritual emergency that took place at an intensive meditation retreat he was leading.

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

Mystical Experience

The definitions of mystical experience used by researchers and clinicians vary considerably, ranging from Neumann's (1964) "upheaval of the total personality" to Greeley's (1974) "spiritual force that seems to lift you out of yourself" to Scharfstein's (1973) "everyday mysticism." A definition of mystical experience both congruent with the major theoretical literature and clinically applicable is as follows: the mystical experience is a transient, extraordinary experience marked by feelings of unity, harmonious relationship to the divine and everything in existence, as well as euphoria, sense of noesis (access to the hidden spiritual dimension), loss of ego functioning, alterations in time and space perception, and the sense of lacking control over the event (Allman, De La Roche, Elkins & Weathers, 1992; Hood, 1974; Lukoff & Lu, 1988).

Numerous surveys assessing the incidence of mystical experience (Allman et al., 1992; Back & Bourque, 1970; Gallup, 1987; Hood, 1974; Spilka, Hood & Gorsuch, 1985; Thomas &

Cooper, 1980) indicate that 30-40% of the population have had mystical experiences, suggesting that they are normal rather than pathological phenomena. While mystical experiences are associated with lower scores on psychopathology scales and higher psychological well-being than controls (Greeley, 1974), case studies document instances where mystical experiences are disruptive and distressing. This is one type of spiritual problem that psychologists see regularly. In a survey, psychologists reported that 4.5% of their clients over the past 12 months brought a mystical experience into therapy (Allman et al., 1992). In the first case below, the mystical experience led to a spiritual problem, but not a spiritual emergency.

A woman in her early thirties sought out therapy to deal with unresolved parental struggles and guilt over a younger brother's psychosis. Approximately two years into her therapy, she underwent a typical mystical experience, including a state of ecstasy, a sense of union with the universe, a heightened awareness transcending space and time, and a greater sense of meaning and purpose to her life. For ten days, she remained in an ecstatic state. She felt that everything in her life had led up to this momentous experience and that all her knowledge had become reorganized during its course. Due to the rapid alteration in her mood and her unusual ideation, her therapist considered diagnoses of mania, schizophrenia, and hysteria. But he rejected these because many aspects of her functioning were either unchanged or improved, and overall her experience seemed to be "more integrating than disintegrating...While a psychiatric diagnosis cannot be dismissed, her experience was certainly akin to those described by great religious mystics who have found a new life through them" (p. 806).

This experience increasingly became the focus of her continued treatment, as she worked to integrate the insights and attitudinal changes that followed. The therapist reported that the most important gain from it was a conviction that she was a worthwhile person with worthwhile ideas, not the intrinsically evil person, 'rotten to the core', that her mother had convinced her she was. Her subsequent treatment focused on expanding the insights she had gained and on helping her to integrate the mystical experience. (adapted from Group for the Advancement of Psychiatry, 1976)

The second case (Lukoff & Everest, 1985) fits the spiritual emergency model in that the mystical experience led to a crisis, which resulted in hospitalization and medication that probably were not necessary.

At age 19, after returning home from hitchhiking in Mexico, Howard became convinced that he was on a "Mental Odyssey." To his family and friends, he began speaking in a highly metaphorical language. For example, after returning from a simple afternoon hike up a mountain, he announced to his parents that "I have been through the bowels of Hell, climbed up and out, and wandered full circles in the wilderness. I have ascended through the Portals of Heaven where I established my rebirth in the earth itself, and now have taken my rightful place in the Kingdom of Heaven." To one friend, he stated: "I am the albatross; you are the dove." The unusual actions and content of his speech led his family to commit him to a psychiatric ward where he was diagnosed with acute schizophrenia.

Once admitted to the hospital, Howard asked to see a Jungian therapist, but this request was ignored and he was given thorazine. While in the hospital, he continued his self-proclaimed odyssey by drawing elaborate "keys" that were mandalas stocked with many well-known symbols and cultural motifs, including the Islamic crescent and star, the yin yang symbol, the infinity sign, and pierced hands, eyes, and circles. In the hospital, he also conducted elaborate

self-designed "power" rituals and rituals to the four directions, despite being on high doses of medication. After two months in the psychiatric hospital, his psychiatrist wanted to transfer him to a long-term facility for further treatment, but he refused to go and was discharged. He left feeling totally exhausted, physically and emotionally, but he continued exploring the mythological, philosophical and artistic parallels to his "Mental Odyssey." He read works by Joseph Campbell and C. G. Jung and joined a "New Age" religious group where he encountered many similar motifs.

In the subsequent 24 years, he has not been hospitalized or on medication, has held positions as an operator of high tech video editing equipment, and completed a college degree. When interviewed 11 years after the episode for a case study, he maintained that, "I have gained much from this experience. I am sorry for the worry and hurt that it may have caused my family and friends. These wounds have been slow to heal. I am deeply grateful for the great victory of my odyssey. From a state of existential nausea, my soul now knows itself as part of the cosmos. Each year brings an ever increasing sense of contentment." (adapted from Lukoff and Everest, 1985, pp. 127-143)

The mystical nature of his experience is evidenced by his euphoria, intense sense of noesis, and feeling of direct connection to transcendent forces. He also had the several of the prognostic signs indicating that a positive outcome would be likely: acute onset, good pre-episode functioning, and exploratory attitude (Lukoff, 1985). Thus he serves as an example of how a spiritual emergency client, who in all likelihood could have been treated on outpatient basis without medication, was unnecessarily and inappropriately hospitalized.

Near-Death Experience (NDE)

The 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. It usually includes dissociation from the physical body, strong positive affect, and transcendental experiences. Phenomenologically, there is a characteristic temporal sequence of stages: peace and contentment; detachment from physical body; entering a transitional region of darkness; seeing a brilliant light; and passing through the light into another realm of existence) (Greyson, 1983). While only 1/3 of persons who survive an encounter with death have this type of NDE (Ring, 1990), modern medical technology has resulted in many persons experiencing NDEs. In 1982, Gallup estimated that approximately 8 million American adults have had a NDE with at least some of the features described above.

Although positive personality transformations frequently follow a NDE, significant intrapsychic and interpersonal difficulties may also arise (Greyson & Harris, 1987). Many individuals report that they doubted their mental stability, and therefore did not discuss the NDE with friends or professionals for fear of being rejected, ridiculed, or regarded as psychotic or hysterical. 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 straightjacket on me" (Sabom & Kreutziger, 1978, p. 2). A hospitalized patient recounted that, "I tried to tell my nurses what had happened when I woke up, but they told me not to talk about it, that I was just imagining things" (Moody, 1975, p. 87). Even religious professionals have not always been sensitive to the spiritual dimensions of such experiences: "I tried to tell my minister, but he told me I had been hallucinating, so I shut up" (Moody, 1975, p. 86).

Fortunately, the many published scientific articles and first person accounts have resulted in greater sensitivity to these experiences (Basford, 1990; Kason & Degler, 1994). NDEs are recognized as fairly common occurrences in modern ICUs, as is the need to differentiate between ICU psychoses and NDEs, and the importance of not "treating" NDEs with antipsychotic medication (Greyson & Harris, 1987). In a recent publication, Greyson (1997) described the distress associated with NDEs as a Religious or Spiritual Problem and noted that, "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" (p. 327).

Leaving a Spiritual Teacher or Path

Persons transitioning from the "culture of embeddedness" with their teachers into more independent functioning often seek psychotherapeutic help (Bogart, 1992). Vaughan (1987) reports that many individuals who have left destructive spiritual teachers reported that the experience ultimately contributed to their wisdom and maturity through meeting the challenge of restoring their integrity. One such case was described by Bogart (1992):
Robert had spent 8 years as the disciple of a teacher from an Asian tradition that emphasized surrender and obedience. Robert had become one of the teacher's attendants, and reported that he "Loved the teacher very much." Yet there were difficulties. The guru frequently embarrassed Robert publicly, humiliating him in front of large classes and castigating him for incompetence. He even physically beat Robert in private. But Robert didn't rebel and hoped that by continuing to remain under the teacher's guidance, he might yet win great praise, confirmation, or sponsorship from his mentor that would enable him to advance spiritually.

Robert left the community after the guru's sexual and financial misconduct were revealed. Upon leaving, he had intense and at times even paralyzing feelings of betrayal, anger, fear, worthlessness and guilt. Robert went into psychotherapy with a spiritually sensitive therapist. Later in psychotherapy, he realized that his relationship with the guru replicated his relationship with his father--an angry alcoholic who had humiliated and physically injured Robert, but whose approval he had nevertheless sought. He also worked on major issues around establishing a life outside the structure of the spiritual community and integrating his spiritual beliefs and practices into this new life. (adapted from pp. 4-5, 16-17)

Spiritual Emergence

In spiritual *emergence*, (another term from the transpersonal psychology literature), there is a gradual unfoldment of spiritual potential with minimal disruption in psychological/social/occupational functioning, whereas in spiritual *emergency* there is significant abrupt disruption in psychological/social/occupational functioning. The Benedictine monk, Brother David Steindl-Rast, describes the process: "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 or called to be integrated or challenged to be integrated" (cited in Bragdon, 1994, p. 18). While less disruptive than spiritual emergencies, emergence can also lead persons to seek out a therapist to help integrate their new spiritual experiences (Grof, 1993).

Differential Diagnosis Between Mental Disorders and Spiritual Emergencies

Making the differential diagnosis between a spiritual emergency and psychopathology can be difficult because the unusual experiences, behaviors and visual, auditory, olfactory or kinesthetic perceptions characteristic of spiritual emergencies can appear as the symptoms of mental disorders: delusions, loosening of associations, markedly illogical thinking, or grossly disorganized behavior. For example, the jumbled speech of someone trying to articulate the noetic quality of a mystical experience can appear as loose associations. Or the visions of a NDE can appear as hallucinations. Or the need for solitude and quiet of a person in a spiritual emergency can appear as catatonia or depression-related withdrawal (Bragdon, 1993). Wilber (1993) argues that the distinction between spiritual emergencies and psychopathology hinges on the critical distinction between pre-rational states and authentic transpersonal states. The "pre/trans fallacy" involves confusing these conditions, which is easy to do. "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, 1993, p. 125).

Lending further credibility to the existence of spiritual emergency as a valid clinical phenomenon, there is considerable overlap among the criteria proposed by different authors for making the differential diagnosis between psychopathology and spiritual emergencies. These constants include: 1) cognitions and speech thematically related to spiritual traditions or to mythology; 2) openness to exploring the experience; 3) no conceptual disorganization (Buckley, 1981; Grof & Grof, 1989; Lukoff, 1985; Watson, 1994). Lukoff (1985a) suggested using good prognostic signs to help distinguish between psychopathology and spiritual emergencies, including: 1) good pre-episode functioning; 2) acute onset of symptoms during a period of three months or less; 3) stressful precipitants to the psychotic episode; and 4) a positive exploratory attitude toward the experience. These criteria have been validated in numerous outcome studies from psychotic episodes (reviewed in Lukoff [1985a]), and would probably also identify individuals who are in the midst of a spiritual emergency with psychotic features that has a high likelihood of a positive outcome.

Spiritual Problems Concomitant With DSM-IV Mental Disorders

All of the cases of spiritual problems described above are not mental disorders, nor associated with co-existing mental disorders. But clients may also present with spiritual problems that are associated with mental disorders. The DSM-IV, specifically notes that an individual can be diagnosed with both a mental disorder and a related problem, as long as "the problem is sufficiently severe to warrant independent clinical attention" (p. 675). Thus, for example, Religious or Spiritual Problem could be coded *along with* Bipolar Disorder (both on Axis I) if the religious/spiritual content (frequently observed in manic states [Goodwin & Jamison, 1990; Podvoll, 1990] is also addressed during treatment of a manic episode. This greatly expands the potential usage of this category since the symptoms and treatment of many mental disorders include religious and spiritual content, especially substance abuse disorders (where the treatment frequently includes 12-step programs) and psychotic disorders, although dissociative, mood, and obsessive compulsive disorders often present with significant religious and spiritual issues as well (Robinson, 1986).

Psychotherapeutic Approaches for Spiritual Problems

First it should be noted that religious and spiritual experiences usually are not distressing to the individual and do not require treatment of any kind. However, some spiritual conflicts do lead persons to seek therapy. There are published cases studies illustrating sensitive ways to conduct psychotherapy utilizing a wide range of therapeutic approaches (e.g., psychoanalytic [Finn & Gartner, 1992], cognitive-behavioral [Propst, 1980] , transpersonal [Chinen, 1988]). Rational emotive therapy is one exception where published material consistently shows a hostile attitude toward spirituality and religion (e.g., Ellis, 1980).

However, for spiritual emergencies, most of the models of intervention come from the transpersonal psychology literature. Grof and Grof (1990) recommend that the person temporarily discontinue active inner exploration and all forms of spiritual practice, change their diet to include more "grounding foods" (such as red meat), become involved in very simple grounding activities (such as gardening), engage in regular light exercise (such as walking), and use expressive arts (such as drawing, clay and evocative music) to allow the expression of emotions and experiences through color, forms, sound and movement. In the case described above, Kornfield made use of most of these elements to avoid hospitalizing the individual who entered a spiritual emergency during a meditation retreat. Reliance on the client's self-healing capacities is one of the main principles that guides transpersonal treatment of spiritual emergencies (Perry, 1974; Watson, 1994). In addition, psychologists should be willing to consult, work closely with or even refer to spiritual teachers who may have considerably more expertise in the specific types of crises associated with a given spiritual practice or tradition. Unfortunately mental health professionals rarely consult with religious professionals or spiritual teachers even when dealing religious and spiritual issues (Larson, Hohmann, Kessler, Meador, Boyd, & McSherry, 1988).

Another key component of treatment of spiritual emergencies is normalization of and education about the experience. While this is a common technique in therapy, it plays an especially important role with spiritual emergencies because persons in the midst of spiritual emergencies are often afraid that the unusual nature of their experiences indicates that they are "going crazy" (as described in some of the above cases). An extremely abbreviated version of normalization of an unusual spiritual experience is reported by Jung (1964) 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. (p. 69)

A complete mind/body/spirit integrated approach to spiritual emergencies would also make use of alternative therapeutic treatments such as diet, bodywork, exercise and movement, homeopathy, herbs (just to name a few) (Bragdon, 1993: Cortright, 1997). There may even be times when medication can play a role in recovery and integration of these experiences.

Increasing Incidence of Spiritual Experiences and Problems

On virtually all measures, there has been a major decline in the strength of the mainstream religious institutions and confidence in religion and religious leadership in American culture (Princeton Religious Research Center, 1985; Stark & Bainbridge, 1985). While 70% of Americans report in Gallup polls that they attend church regularly (Gallup, 1987), a recent study of the actual religious behavior of Americans found that half of persons who tell pollsters that they attend church regularly are not telling the truth. Kosmin and Lachman (1993) conducted an in depth interview study (rather than a simple poll as has been used in most studies) with 4001 randomly selected individuals about the nature and frequency of church attendance, and membership in a denomination. By also tracking attendance at churches, they found that only 19% of adult Americans regularly practice their religion. Some 22.5% exhibit "only trace elements" of religion in their lives; another 29% were rated as barely or nominally religious, and 7.5% describe themselves as agnostics. The researchers concluded that most Americans claim a religion that does not significantly inform their attitudes or behavior.

Yet at the same time people are turning away from conventional religious institutional forms, the number of people who report that they personally believe in God or some spiritual force, who pray or engage in some spiritual practice, and who report a mystical experience has been increasing. In one survey, 75% of persons who are not members of a church or synagogue say that they pray sometime during their everyday lives, and 58% of Americans reported the need to experience spiritual growth (Woodward, 1994). During the last 25 years, there has been a significant increase in people adopting spiritual practices, including a wide array of meditation, marital arts, tai chi, chanting, and yoga techniques. There has also been an explosion of interest in mystical, esoteric, shamanic and pagan traditions that involve participation in sweat lodges, goddess circles and the rituals of many small new spiritual schools and "New Age Groups" (Lewis & Melton, 1992). Twelve step programs, with their focus on a "higher power" and spiritual awakening, have been developed for a wide-range of problems and have millions of adherents. Psychospiritually-oriented cancer support groups are another recent phenomenon.

Gallup polls (1987) have shown an increase in percentages of people who report: mystical experiences (from 35% in 1973 to 43% in 1986), contact with the dead (from 27% in 1973 to 42% in 1986), ESP (from 58% in 1973 to 67% in 1986), visions (from 8% in 1973 to 29% in 1986) and other unusual experiences. Based on his 15 years of survey research, Greeley (1987) concluded, "More people than ever say they've had such experiences... whether you look at the most common forms of psychic and mystical experience or the rarest...These experiences are common, benign and often helpful. What has been 'paranormal' is not only becoming normal in our time--it may also be health-giving" (p.49). Even such unusual experiences as UFO abductions (Ring, 1992), paranormal (Braud, 1995; Hastings, 1983), and out-of-the-body experiences (Gabbard & Twemlow, 1984) are often experienced as meaningful, positively transformative, and spiritual. Accordingly, as the number of persons who engage in spiritual practices and have spiritual experiences increases, it seems likely that the incidence of spiritual problems seen in psychotherapy will also grow.

Conclusion

To date, religious problems have received much more attention than spiritual problems in the clinical and research literature. There is a handbook (Wicks, Parsons & Capps, 1993) and about a dozen journals devoted to pastoral counseling, several more to "Christian psychiatry," as well as professional organizations and conferences that address religious problems. There are no journals focused on spiritual problems. Transpersonal psychologists actively investigate both spiritual experiences that are trans, beyond our ordinary personal and biological self, and also spiritual practices such as Zen Buddhism and Patanjali Yoga, which are designed to lead to intense spiritual experiences (Rao, 1995). While transpersonal psychology is avowedly nonsectarian (Lajoie & Shapiro, 1992), many transpersonal psychologists are hopeful that the systematic study of these spiritual practices and their associated experiences can facilitate their occurrence in their clients (when clinically appropriate) (Tart, 1995). But this requires sensitivity to the types of problems that are also associated with specific practices.

Religious and spiritual problems need to be subjected to more research to better understand their prevalence, clinical presentation, differential diagnosis, outcome, treatment, relationship to the life cycle, ethnic factors and predisposing intrapsychic factors. While defining discrete religious and spiritual problems for study clearly presents difficulties, such as the frequent overlap in the categories discussed above, the extensive and rigorous research on the phenomenology, prevalence, outcome, clinical sequalae, treatment of NDEs serves as a model demonstrating that the obstacles are not insurmountable (Greyson, 1983, 1997; Greyson & Harris, 1987; Ring, 1990, 1992). The acceptance of religious and spiritual problems as a new diagnostic category in DSM-IV is a reflection of increasing sensitivty to cultural diversity in the mental health professions and of transpersonal psychology's impact on mainstream clinical practice.

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