Religious and Spiritual Problem V-Code: An Adlerian Assessment

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Abstract

The author considers the adequacy and clinical usefulness of the *DSM-IV* V-code, "religious and spiritual problems," and how Individual Psychologists might use it. The author first situates the code within its developmental context and provides a brief description of problems that can be classified in this area, differentiating them from commonly mistaken psychological problems. He then reviews the literature that stresses the importance of therapists' incorporating some level of religious and spiritual understanding of their clients into therapeutic practice. The author identifies Adler's construct of *Gemeinschaftsgefühl* as the norm by which the general health of the client can be determined. Based on this norm, specific criteria are presented for helping determine the general health of one's religious or spiritual movement. The author concludes with special attention paid to a practical application of these criteria to aspects of client spirituality.

The inclusion of the V-code, "religious or spiritual problem," within the *Diagnostic and Statistical Manual* (4th edition, *DSM-IV*) and continuing through the text revision is a tribute to the efforts of transpersonal psychologists. According to one of the primary designers and co-authors of the category, David Lukoff (1998), three main issues precipitated its inclusion in *DSM-IV*. First, the frequency of such problems occurring clinically was found to be greater than once thought, and it continues to rise. This has been documented in numerous surveys of the American Psychological Association. For example, Shafranske (2000) reported that among psychiatrists responding to a national survey, almost half of their clients "reported that religious or spiritual issues were involved in psychiatric treatment often or a great deal of the time" (p. 528). Second, there was a need for training psychologists in the areas of religion and spirituality. This, too, has been documented from both the psychological and religious sides for many years (e.g., Küng, 1990; Miller, 1999). Currently, this is being addressed by the inclusion of religious and spiritual competence factors in therapist and counselor training programs (Larson, Lu, & Swyers, 1996; Puchalski & Larson, 1998; Sansone, Khatain, & Rodenhauser, 1990). Third, there were concerns about addressing the ethics of cultural sensitivity related to religion and spirituality. Within the last decade, for example, the *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 1992) has recognized the need to address this aspect of cultural sensitivity.

The Journal of Individual Psychology, Vol. 58, No. 4, Winter 2002
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These three issues gave rise to the broader concern for determining what issues constitute a religious or spiritual problem. Such considerations are salient for both secular and pastoral counselors today. In this article, I explore several aspects of this broader concern. I review the development of the category, differentiate religious and spiritual problems from other common psychological difficulties, address the matter of dealing with the problems from a religiously informed secular therapeutic approach, and conclude with specifically Adlerian considerations about the purpose and communal function of behaviors that merit such categorization.

Development of the V-Code

Stanislav and Christina Grof founded the Spiritual Emergency Network in 1980 (Prevatt & Park, 1989). The Grofs were primarily concerned about the psychological difficulties being encountered by North Americans who engaged in Asian meditative practices introduced to the United States in the 1960s. They coined the term "spiritual emergency" to identify this phenomenon. Spiritual emergencies can be identified

> 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)

The Grofs and like-minded colleagues (e.g., Armstrong, 1989; Greenwell, 1990; Lukoff, 1991; Silverman, 1967) refined a typology of spiritual emergencies to include almost a dozen discernable states, which they contended have been "described in sacred literature of all ages as a result of meditative practices and as signposts of the mystical path" (Grof & Grof, p. x). The development of the *DSM*-category transformed, however, from concern over specific spiritual emergencies to a more general concern over religious or spiritual problems.

Lukoff (1998) noted that in the mid-1980s, the renamed Spiritual Emergence Network became concerned about the frequent pathologizing of clients' spiritual crises. The Network members determined that the best way to sensitize clinicians to religious and spiritual matters in therapy would be to recommend a new diagnostic category. Lukoff (1985) proposed the category as "Mystical Experience with Psychotic Features"—drawing an explicit analogy with "Uncomplicated Bereavement," which was already recognized in

DSM-III-R (American Psychological Association, 1987) as one of the conditions "not attributable to a mental disorder that are a focus of attention or treatment" (p. 361). He reasoned that those who experience turbulent spiritual experiences might be misperceived to suffer from a mental disorder when these are seen out of context. Their reactions may be altogether normal, however, if the religious or spiritual context within which the experience occurs is understood (Lukoff, 1988). The Network members saw other benefits to diagnostic categorization as well, including more accurate diagnoses when religious and spiritual concerns arise and reducing the harm that results when patients are misdiagnosed. They also believed further treatment benefits would come from research and training on the new category.

Based on consultation with field experts and extensive literature searches (Lukoff, Turner, & Lu, 1992, 1993), a proposal for "Psychoreligious or Psychospiritual Conflict" was put forward to the Task Force on *DSM-IV*. Lukoff (1998) wrote that replacing the term "conflict" with "problem" in the final proposal was intentional. This was used to keep the descriptor more in line with the V-code language already in use (e.g., "Parent-Child Problem," "Phase of Life Problem"). The official proposal was published in the *Journal of Nervous and Mental Disease* (Lukoff, Lu, & Turner, 1992) and the Task force accepted an abbreviated form in January 1993 with the title changed slightly (dropping the prefix "psycho") from the original:

> *V62.89 Religious and Spiritual Problems:* 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)

Differentiating within the V-code and Distinguishing from Mental Disorder

Given this development "from spiritual emergency to spiritual problem" (Lukoff, 1998), Sperry (2001) proposed that it remains helpful for clinicians to differentiate spiritual crises from spiritual emergencies within the category. For example, because some consider spirituality to be central to human experience (e.g., Bergin, Payne, & Richards, 1996; Browning, 1987), Sperry suggested that most crises could be considered spiritual in nature. "During a crisis," he wrote, "an individual's sense of coherence and faith in the continuity of life is shaken, or even shattered, by the stress of a life event. . . . The core elements of an individual's being and connectedness to others are often stretched to the breaking point" (p. 80). As an aid in identifying such crises, Sperry (p. 81) included McBride's (1998) list of common spiritual crises for consideration: trauma, relationships and family problems, disillusionment

with the Church, belief transition, denominational identity, losses, physical illness, extremes of thinking or living, psychological disturbance, religious burnout, ethic conflicts, personal identity, and the crisis of working with people in crisis.

At the same time, Sperry (2001) differentiated the just mentioned life crises, those that have a spiritual dimension, from the emergencies that are precipitated directly by one's spiritual practices. According to Grof and Grof (1989), spiritual emergencies are specifically those crises that arise "when a process of growth and change become chaotic and overwhelming" (p. x). Sperry agreed that these must be differentiated from psychoses, something especially important among those who have no obvious predisposition to mental illness or impaired functioning. He described the spiritual emergencies most familiar to the American public: peak experiences, near-death experiences, possession states, past-life experiences, experiences of UFO encounters, communicating with spirit guides and channeling, the crisis of psychic openings ("an influx of information from nonordinary sources such as telepathy, clairvoyance, . . . out of body travel," p. 84; see Armstrong, 1989), psychological renewal through return to the center (experiencing "a death followed by a regression to the beginning of their lives wherein a clash between the cosmic forces of good and evil is reenacted," p. 84), the awakening of kundalini (when "the body's energy centers or chakras . . . [release] new levels of consciousness which can have a spiritual function," p. 84; see Greenwell, 1990), and shamanic crisis ("the initiation experience of shamans," p. 85; see Lukoff, 1991).

This task of differentiating religious or spiritual problems from mental disorders and psychosis, then, is an increasingly important priority for therapists. Sperry (2001, p. 85) consolidated the criteria for differential diagnoses as follows:

> *Brief Psychotic Disorders:* One or more of the following: delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior. (*DSM-IV*)
>
> *Spiritual Emergency:* Changes in consciousness in which there is significant transpersonal emphasis; the individual's capacity to view the condition as an inner psychological process and approach it in an inner way; and the capacity to form an adequate therapeutic alliance and maintain a spirit of cooperation. (Grof & Grof, 1989)
>
> *Spiritual Experience with Psychotic Features:* Ecstatic mood; sense of newly gained knowledge; if present, delusions with mythological themes; and no conceptual disorganization. (Lukoff, 1985)

One specific and highly significant differentiation found frequently in the literature is the delineation between "dark night of the soul" experiences and clinical depression (Cronk, 1991; Dombrowski, 1992; May, 1992; Sperry,

2001). This differentiation is of particular importance because of the frequent occurrences of the two and their easy confusion. The identification of "dark night" experience derives from the writings of the 16th Century Carmelite priest, John of the Cross, and as such is a Christian formulation that may or may not extend beyond that religion. It refers to a two-part experience that results in the usually temporary loss of all sense of relationship with God and spiritual contentment. When an individual no longer experiences comfort or a sense of closeness to God from his or her spiritual practices, the "night of the senses" is said to have arrived. In spite of continued commitment to one's spiritual path, such emptiness can build and lead to a sense of complete alienation from God, or the "night of the spirit." Because such deep feelings of bereavement can lead to clinical depression, it is all the more important to identify the "dark night" experience early on. If the individual is not provided appropriate direction, it can bring about an actual crisis of faith (Dombrowski, 1992).

Cronk (1991) differentiated the "dark night" experience from another V-code. "Bereavement (V62.82)," experienced at the loss of a significant person in one's life, is identified when, "as part of their reaction to the loss, some . . . individuals present with symptoms characteristic of a Major Depressive Episode [but] typically regard the depressed mood as 'normal'" (*DSM-IV*, p. 684). Cronk differentiated the two by watching for the person's ability to move into a receptive mode as if God intends thereby to convey something to the individual, the ability to face the experience of spiritual dryness rather than withdraw from it, and the person's ability to sustain work and social relationships rather than avoid them (p. 87).

May (1992) offered a more detailed differentiation that contrasts the symptoms of depression with characteristics of "dark night" experiences. Among the differences, he highlights the following (p. 90):

1. Where loss of effectiveness in work or life generally is characteristic of depression, it is not prominent in "dark night" experiences.
2. The cynicism and bitterness frequently experienced by depressed persons is notably absent, and a sense of humor is retained in "dark night" experiences.
3. The self-focus of depression is not present in "dark night" experiences but rather a compassion for others' suffering.
4. Where a plea for help is characteristic of depression, those experiencing the "dark night" are generally accepting of their predicaments.
5. Working with depressed clients' unexpressed anger can engender feelings of annoyance and frustration in the therapist, while working with individuals experiencing a "dark night" experience may bring about feelings of consolation in the therapist.

Differentiating diagnoses in this area—distinguishing religious or spiritual problems from mental disorders—is a complex undertaking and cannot be accomplished *solely on the basis of their objective, observable spiritual context*. At least two other, more subjective areas should also be considered: the therapeutic and spiritual insight of the therapist as well as an analysis of the purpose served by the precipitating events.

Therapists' Spiritual Acumen

Over the last several years there has been a dramatic change in thinking within the helping professions about whether therapists should concern themselves with religion and spirituality. Only a decade and a half ago, in an invited lecture to the American Psychiatric Association, Swiss theologian, Hans Küng (1990) was able to undertake "a systematic investigation of the repression of religion in psychiatry, psychotherapy, and psychoanalysis" (p. xiv). In 1986, the American Psychiatric Association Committee for Psychiatry and Religion had just commissioned its report on the psychology of "zealous and cohesive cult-like groups" (quoted in Küng, 1990, p. 128). Küng expressed concern for both the religious and psychological sides of the subsequent debate:

> [On the one hand,] those elements of protest, of resistance, and of alternatives to bourgeois banality . . . that find expression in new religious currents should not be reduced to a psychological syndrome; [on the other hand,] far too seldom do psychiatrists constructively confront religiousness—including their own religiousness, or irreligiousness—in their professional (and perhaps also their personal) lives. (p. 129)

Less than two decades later, a vast body of literature (see especially Lukoff, Turner, & Lu, 1992, 1993; Shafranske, 2000) attests to the willingness of the profession to include religion and spirituality in its conceptualizations of illness and health (Bergin, 1983; Larson & Larson, 1994; Mathews, Larson, & Barry, 1993), to examine the field's willingness to remediate the problem through professional training (Larson, Lu, & Swyers, 1996; Sansone, Khatain, & Rodenhauser, 1990), and even to examine their own religiousness (Bergin & Jensen, 1990; Shafranske & Maloney, 1990). In this literature, special attention has been drawn to the manner in which therapists incorporate the *spiritual dimension into their clinical practices*. For example, various combinations of approaches can be employed, including:

> (1) [Incorporating a] spiritual assessment; (2) processing patients' religious and spiritual issues, using spiritual practices with patients, or both; (3) developing an integrative philosophy of clinical practice involving the spiritual dimension;

> and (4) integrating the spiritual dimension and spiritual practices into [their] personal lives. (Sperry, 2000, pp. 519–520)

So, whether accomplished by a secular therapist or pastoral counselor, the assessment of religious and spiritual functioning is a serious undertaking among helping professionals today (Larson, Lu, & Swyers, 1996; Peteet, 1994; Puchalski & Larson, 1998). Concern for understanding the client's religiousness or spirituality is not, however, an altogether neutral endeavor. If repression of religion (Küng, 1990) is no longer the custom within the helping professions, neither is uncritical acceptance of all spiritual movement the norm among religionists. The relationship between religion or spirituality and psychotherapy calls for respectful, if critical consideration; one that recognizes the expertise inherent in each discipline as well each other's limitations.

Purposefulness of Religious or Spiritual Problems

Individual Psychology is a values-oriented psychology (Ansbacher, 1971; Ecrement & Zarski, 1987, Watts, 2000) that espouses a specific standard for determining mental health. The term Adler most frequently used to embody ideal mental health was *Gemeinschaftsgefühl*—a term that intended to convey the connection of humans in space and time and their obligations to one another in the advancement of the species toward a perfect community within which all have a place (Ansbacher, 1992). In light of this construct, Adler's psychological theory espouses a normative approach to the individual and to humanity as a whole: because all problems arise from the social context, they are best resolved by greater social interest. From Adler's viewpoint, interdependence is more beneficial to the individual and the group than extreme independence from others or dependence on them. The ceaseless striving of humanity to overcome its circumstances is best applied to finding a place among others, rather than in dominating them. Adler (1933/1964) understood religion, and especially the concept of a monotheistic God, to reflect "the same ruling, perfection-promising, grace-giving goal of overcoming. [Humanity's] hourly concern, . . . the compulsion toward the ascendance of the whole and the parts . . . leads to the most profound recognition of interconnectedness" (pp. 278–279). To the degree that an individual's behavior derives from or leads to self-boundedness (as if the individual can act without concern for his or her relationship to humanity), it is considered unhealthy—unhelpful for the common good. "The self-bound individual," Adler wrote, "always forgets that his self would be safeguarded the better and more automatically, the more he would prepare himself for the welfare of mankind" (p. 301).

The Individual Psychologist evaluates religious or spiritual problems in the same light. "Distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values" (*DSM-IV*, p. 685) are considered as to whether they move the individual cooperatively toward others and the goal of human well-being, or whether they move one to act against others' well-being. Understanding *Gemeinschaftsgefühl* as Adler's norm of mental health provides Individual Psychologists access to the spirituality literature and an appropriately critical point of collaboration with the *DSM-IV*.

Based on the work of spirituality scholar Sandra Schneiders (1986, 1989, 1998), I have suggested (2000, 2001) specific Adlerian criteria for determining the relative wellness of the individual's spiritual movement. Briefly stated, the criteria inquire about the coherence of certain aspects of one's spirituality to the person's ultimate value, the level of one's personal integration, the direction of one's striving, and one's commitment to self-transcendence:

- Wellness is determined to the degree that one's ultimate value promotes useful open-minded integration, striving, and self-transcendence. Adler (1933/1964) believed that one's ultimate value "always reflects . . . the goal of overcoming." He wrote that this was the case "whether one calls the highest effective goal deity, or socialism or [as he did], the pure idea of social interest" (p. 278).
- Wellness is determined to the degree that spiritual integration includes openness and tolerance of other pathways in spite of holding steadfast to one's core beliefs. "It is the feeling of insecurity," insisted Adler (as cited in Ansbacher & Ansbacher, 1956), "which forces the neurotic to a stronger attachment to fictions . . . ideals, and principles. . . . To [the normal person] they are a figure of speech, . . . he does not lack the open-mindedness . . . to free himself from these fictions and to reckon with reality" (p. 246).
- Wellness is determined to the degree that spiritual striving, too, is on the "useful" side of life. For Adler (1929/1964) this meant "in the interests of mankind generally" (p. 78).
- Wellness is determined to the degree that self-transcendence occurs; that is, to the degree that one moves away from self-boundedness and radical independence, and toward interdependence. The interdependent community toward which the individual moves "embraces . . . not only the human community, but . . . the whole of life. . . . It means the human being's sense of himself as a part of the unity of existence in contrast to the fear of standing in the cosmos [as] a single unrelated organism" (Way,

1950, p. 176). Ansbacher (1968/1991) also suggested that "the opposite of self-centeredness might . . . be called self-transcendence" (p. 32). This is first a movement within one's current reality and only in theistic belief need it take on supernatural aspects.

Each of these criteria is rooted in Adler's conceptualization of *Gemeinschaftsgefühl*. The following applies this norm to practical examples of what might be diagnosed as religious or spiritual problems. Theologian and psychologist Daniel Helminiak's conditions for therapeutic interaction with clients' spiritual movement are examined in the remainder of this article. His examples are supplemented with references to clinical studies of the psychology of religion.

Determining Counselor Intervention

Helminiak (2001a) insisted that while therapists can be open "to a range of client values," some of these values can and at times do exclude fostering "the human good" (p. 242). That is, all aspects of spirituality do not promote mental health. For him (2001b), it is an act of responsibility for the therapist to differentiate these aspects of spirituality. The therapist can respond by (a) validating various facets of the client's spirituality, (b) reinterpreting them, or (c) rejecting them outright (p. 173).

For Helminiak, aspects of spirituality that facilitate psychological healing and personal integration include belief in a loving and caring God, the need to make some sense of life's happenings, commitment to honesty, compassion, and membership in a supportive community. Such aspects coincide closely with the wellness measures of one's ultimate concern, integration, striving on the useful side of life, and self-transcendence. These can and should be "validated," Helminiak wrote. "To the extent that these beliefs and practices facilitate . . . integration . . . in the client, a therapist's support of them is fostering spiritual growth" (Helminiak, 2001b, p. 174). Josephson, Larson, and Juthani (2000) also document the clinical relevance of mentally healthy religious and spiritual aspects. For example, religious commitment is associated with healthy behaviors and attitudes (e.g., Mathews, McCullough, & Larson, 1998; Oleckno & Blacconiere, 1991). They are also associated with individuals more effectively managing serious medical illness (e.g., O'Brien, 1982; Pargament, 1997) and they may facilitate recovery from episodes of major mental illness (e.g., Koenig & Larson, 1998; Koenig, Larson, & Weaver, 1998).

There are other examples of client spirituality, however, that are more ambiguous than the positive ones just noted. These the therapist may need to "reinterpret" if therapy is to foster "the authentic spirituality that the client

actually desires" (Helminiak, 2001b, p. 174). Helminiak suggested that even common activities, such as prayers of petition, could be self-destructive. They are destructive to the degree that, for instance, personal work that could contribute to a needed outcome is neglected in passive hope of a miracle. Such destructive inactivity is characterized by Individual Psychologists as striving on the useless side of life. Similarly, a client's self-destructive image of God (the spiritual wellness criterion addressing ultimate value) may be helpfully reinterpreted from one that slavishly demands meeting the expectations of family or the local congregation to one of "self-transcendent meaning and wholesome purpose in life" (p. 175). Josephson, Larson, and Juthani (2000) also acknowledged that one of the many clinical benefits of assessing client spirituality can be the opportunity of appropriately redirecting the client "toward reevaluation of his or her worldview" (p. 537).

Still more necessary for the mental health and growth potential of the client is the readiness and ability of the therapist to "reject" aspects of spiritual activity that "are antithetical to psychological healing, personal integration, and wholesome growth" (Helminiak, 2001b, p. 177). Among the destructive aspects of personal spirituality, Helminiak mentioned prohibitions against being angry with God and prohibitions against religious questioning. Both prohibitions he saw as deserving of rejection. He recommended rejecting the first to the degree that prohibiting anger blocks emotional insight, insight that can lead to a more integrated personality—a spiritual wellness criterion. He recommended rejecting the second to the degree that closed-mindedness precludes "the client's religious commitment to honesty before God" (p. 178), thus touching on several of the criteria (i.e., ultimate value, integration, and striving). In this category, Helminiak also included a client's belief in "Satanic control and hexes." Such belief can prevent the client from accepting personal responsibility for his or her actions, who may blame them instead on supernatural influences. Josephson, Larson, and Juthani (2000) confirmed concerns about the development of negative God images arising from "rigid religious families whose harsh parenting practices border on abuse" (p. 536; Bowman, 1989) as well as serious mental illness being associated with religious-spiritual pathology (Koenig et al., 1998).

Conclusion

The *DSM-IV* V-code "religious or spiritual problem" is an important advancement in the tool of diagnosis. In spite of the negative potential for labeling religious and spiritual issues in a negative light, the V-code has opened opportunities for better understanding the range of crises and emergencies experienced by religiously and spiritually oriented individuals. It has provided opportunities to differentiate normal life problems that involve one's

religiousness and spirituality from pathological manifestations with religious features.

Development of the V-code has also helped show the importance of therapists' acquainting themselves with the cultural aspects of religion and spirituality and the benefit of studying these areas further. The reader was provided cursory access to studies that pay attention to these concerns and to the need for therapists to be familiar with religious or spiritual movement in their clients' lives. The reader was also introduced to other studies that document the benefits and drawbacks of religiosity and spirituality in clients' lives.

Finally, I have highlighted an Adlerian action orientation. By reviewing current recommendations on validating, reinterpreting, or rejecting aspects of client spirituality, I have argued that Individual Psychologists can adapt this schema by positing *Gemeinschaftsgefühl* as the norm of spiritual well-being.

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