I submit that we fear and hate wholly healthy holy experience.... We are afraid of our souls becoming alive.

R. D. Laing (1987)

To the psychologist, the religious propensities of man [woman] must be at least as interesting as any other of the facts pertaining to his [her] mental constitution.

William James (1961)

Historically, mental health professionals have tended to either ignore or pathologize the religious and spiritual dimensions of life. Freud (1966), the founder of psychoanalysis, saw religion as a, "A system of wishful illusions together with a disavowal of reality, such as we find... nowhere else... but in a state of blissful hallucinatory confusion" and a "universal obsessional neurosis." Skinnerian behaviorism ignored religious experience to focus exclusively on observable behavior. Albert Ellis, the originator of rational emotive (cognitive) therapy, promoted a highly critical view of religion, viewing it as equivalent to irrational thinking and emotional disturbance: "The elegant therapeutic solution to emo-
tional problems is quite unreligious.... The less religious they [clients] are, the more emotionally healthy they will tend to be (Ellis, 1980, p. 637). Thus, at the roots of three major schools of psychology, religion is denigrated (Bergin, 1983, although some contemporary theorists are revising these views, e.g., Lsor, 1989).

Individuals who bring religious and spiritual problems into their treatment are often viewed as showing signs of mental illness (Lukoff & Everest, 1985). Grof (1985) has pointed out that even within the religious community, there is a lack of comprehension of the dynamics and intensity of religious experiences: "If a member of a typical congregation were to have a profound religious experience, its minister would very likely send him or her to a psychiatrist for medical treatment" (p. 335).

William James (1961), considered by many the father of the psychology of religion, did have an open-minded, even positive view of religious experience; however, he did not address the role of religion in psychotherapy. Carl Jung must be given credit for providing the first extensive examination of the role of religion in clinical practice. He saw the development of the client's religious attitudes as central to therapy. For Jung (1972), religion is "an attitude peculiar to a consciousness which has been altered by the experience of the numinous" (p. 6). Numinous he defined as a transformative experience that grips the psyche, thereby providing life with a new sense of orientation and purpose. He saw a major part of Jungian analysis as directed toward facilitating numinous experiences in the client, and thus as having religious overtones.

Unfortunately, Jung's views have not yet had much impact on the practices of mainstream psychiatry and psychology. However, during the last three decades, other attempts have been made to integrate the religious and spiritual dimensions of human existence into theory, research, and practice. Humanistic (third force) and transpersonal (fourth force) psychology, while representing a "minority view" within the mental health disciplines, have provided an enormous stimulus for exploration and research into the realms of religious and spiritual experience.

The authors believe that the scope and volume of theoretical, clinical, and research knowledge concerning religious issues in psychology is now sufficient to influence the practices of mainstream mental health professionals. In addition to Jung's pioneering work, the foundations for such an effort have been laid by: 1) the field of pastoral counseling during the past fifty years (Wicks, Parsons & Capps, 1985); and more recently 2) the spiritual emergency movement (Bragdon, 1988; Grof & Grof, 1989); and 3) the attempts to link transpersonal psychology to the DSM-III-R, the

In a 1985 ITP article, Lukoff proposed a diagnostic category, Mystical Experience with Psychotic Features (MEPF), to identify intense religious experiences that present as psychotic-like episodes. This category built upon the spiritual emergency literature, but was written in the style of DSM-III with operational criteria. In a subsequent 1988 article, Lukoff made an analogy between MEPF and the DSM-III-R category of Uncomplicated Bereavement. They noted that even when the period of bereavement following a significant loss meets the diagnostic criteria for Major Depression, this diagnosis is not given. Rather a V Code, which is a condition not attributable to a mental disorder, should be assigned. As stated in the DSM-III-R, a diagnosis of Uncomplicated Bereavement is appropriate because the symptoms result from "a normal reaction to the death of a loved one" (p, 361). Similarly, Lukoff (1988) argued that individuals in the midst of a tumultuous mystical experience 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).

In early 1991, the authors of this research review embarked on the formidable task of developing a new V Code to be submitted to the American Psychiatric Association's Task Force on DSM-IV (to be published in 1993). Our initial formulation of "Psychospiritual Conflict" was expanded to include the religious domain. This prompted the need to distinguish between religion and spirituality. While there is no consensus about the boundaries between religiosity and spirituality, a frequently drawn distinction in the literature, which we adopted, utilizes the term religiosity to refer to "adherence to the beliefs and practices of an organized church or religious institution" (Shafranske & Maloney, 1990, p. 72). Spirituality is used to describe the transcendental relationship between the person and a Higher Being, a quality that goes beyond a specific religious affiliation (Peterson & Nelson, 1987).

Then, having clarified the distinction between psychoreligious and psychospiritual, 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). In May 1991, we sent a letter informing the Task Force of our intention to submit a V Code Proposal for Psychoreligious or Psychospiritual Problem, and included a definition and examples. In subsequently discussing our plans with several colleagues, Stanley Krippner observed that we had incorporated examples falling outside both the religious and spiritual categories (e.g., out-of-body experiences and various parapsychological experiences).
Hence, we temporarily considered adding a third category entitled "experienced anomalous problem" to encompass such phenomena. However, we later dropped this third category from our proposal, feeling that it warranted separate evaluation as an independent V Code. This process enhanced the conceptual clarity and definitional boundaries of the two remaining categories: psychoreligious and psychospiritual problems.

Recognizing that any proposal to the DSM-IV Task Force needed to be research-based, we then conducted a literature search of Medline, PsycINFO, and the Religion Index. This review established the most prevalent and clinically significant problems within each category, enabling us to arrive at the following working definition for our proposed VCode(to be renamed Z Code in DSM-IV):

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 Z Code 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.

Over the next several months, we explored the incidence, assessment, treatment, differential diagnosis, training, and cultural sensitivity implications for each of the two categories. Finally, in December 1991, the proposal was formally submitted to the Task Force on DSM-IV. The literature review in its entirety appears in Lukoff, Lu, and Turner (in press).

We felt that all three categories that arose in the course of developing our proposal (i.e., psychoreligious, psychospiritual and anomalous) warranted attention in the Research Review section of JTP. In this article, we limit our focus to the psychoreligious category, with future articles planned for the psychospiritual and anomalous categories. In contrast to the fairly limited focus of the V Code proposal, here we are considering the broader range of issues concerning psychoreligious aspects of clinical practice. Thus, in addition to sections included in the proposal on: 1) religiosity in the general public and mental health professions, 2) training, 3) religion and mental health, and 4) treatment, this review also includes sections on: 5) addiction, and 6) ethnic perspectives.
During our computerized search of the literature contained in Medline, PsychINFO, and the Religion Index, we were struck by how few serious scientific investigations have addressed the religious dimensions of human problems and their healing. In the psychiatric and psychological literature, when religion is not being cast in a negative light, the topic is generally ignored. A study of religious variables in articles published in four psychiatric journals during a recent five-year period showed that only 2.5% (59 of 2348) included religious variables, and these were mainly psycho-pathological uses of religion by patients (Larson, Pattison, Blazer, Omran & Kaplan, 1986). Below are the abstracts of the most compelling studies, uncovered in our search, that address the psychoreligious dimensions of healing.

**STUDIES ADDRESSING THE PSYCHORELIGIOUS DIMENSIONS OF PSYCHOLOGICAL HEALING**

*Religiosity of the General Public and Mental Health Professionals*

In the past three decades, surveys conducted in the United States have consistently indicated that religious beliefs and practices are considered highly important by the general public. Unfortunately, published surveys from other societies were not located in the databases searched. In Gallup polls, 89% of adult Americans report that they pray to God, and 69% are affiliated with religious institutions. Between 95-99% claim a belief in God, and 69% believe that God has guided them in making decisions (Gallup, 1985). Similarly, surveys conducted by the National Opinion Research Center reveal that 80% of adult Americans feel at least "somewhat close" to God most of the time. These results parallel those found by surveys of patient populations.


*Method:* The authors studied the religious beliefs, practices, and experiences of 52 psychiatric inpatients. The patients completed a Beck Depression Inventory at the time of the interview. Religious attitudes and involvement were measured by using a questionnaire of religious beliefs, practices, and personal experiences. *Findings:* Results indicated that religious beliefs and practices assumed an important and often central place in the lives of many patients. In accord with national and local public poll results, some 95% professed a belief in
God, and 75% reported the belief that the Bible refers to daily events. Almost two thirds were church members, and over half attended church weekly. The authors concluded that belief in God, and in the teachings of the Bible, the sense of an afterlife, and involvement with a church community are relevant dimensions of our patients' lives that certainly deserve more consideration than the psychiatric profession has customarily provided.

In contrast, studies have consistently shown that mental health professionals place far less importance on religion than the general public and patient populations. In a 1975 survey conducted by the American Psychiatric Association (APA) Task Force on Religion and Psychiatry, about half of the psychiatrists surveyed described themselves as agnostics or atheists. A study of psychologists found that only 43% of the sample stated a belief in a transcendent deity (Ragan, Maloney, & Beit-Hallahmni, 1980). Furthermore, studies have found that both psychiatrists and psychologists are relatively uninvolved in organized religion. Over half of psychiatrists (APA, 1975) and psychologists (Ragan et al., 1980) reported that they attended church "rarely" or "never." In marked contrast, Gallup (1985) found that one third of the population consider religion to be the most important dimension of their life, and another third consider it very important.


Method: A sample of 1000 clinical psychologists was randomly selected from the American Psychological Association Division of Clinical Psychology and sent a 65-item questionnaire; 41% responded. Findings: Only 18% of psychologists agreed that organized religion was the primary source of their spirituality, and 59% reported very little or no involvement with organized religion. However, 52% of psychologists reported spirituality as relevant to their professional life and that 60% of their clients often expressed their personal experiences in religious language. Yet 85% reported the frequency of discussions of these topics during their training to be rare or never.


Method: A survey of 425 therapists representing 59% of a national sampling of clinical psychologists, psychiatrists, clinical social workers, and marriage and family therapists was conducted. Median length of professional experience was 16 years. Findings: To the item, "My whole approach to life is based on my religion," psychologists showed the least agreement (33%) versus 51% for the other mental health professionals and 72% in the general population. Although religious involvement among therapists was below the levels of the general public, 68% of all therapists in this study endorsed the item, "Seek a spiritual understanding of the universe and one's place in it." The
authors concluded that: "Thus there appears to be a significant degree of unrecognized religiousness among therapists."

Clinical Training: Psychoreligious Issues

Despite the importance that religion plays in most patients’ lives, neither psychologists nor psychiatrists are given adequate training to prepare them to deal with issues that arise in this realm. In a survey of members of the American Psychological Association, 83% reported that discussions of religion in training occurred rarely or never (Shafranske & Maloney, 1990). Only one-third felt competent to address religious and spiritual concerns in therapy, and they reported basing their clinical interventions on personal conviction rather than professional training experiences. Anderson, a clinically trained chaplain, and Young, a psychiatrist, both of whom work at an acute psychiatric day hospital, observed that "All clinicians inevitably face the challenge of treating patients with religious troubles and preoccupations" (Anderson & Young, 1988, p. 532). Yet, Post (1990) noted that "Few psychiatrists are trained to understand religion, much less treat it sympathetically" (p. 813). Several recent articles have highlighted the inadequate training given to mental health professionals in the area of religious experience and problems.


Method: 125 training directors of the Association of Psychology Internship Centers (APIe) responded to a 6-page questionnaire concerning the policies, procedures, and practices of their training sites regarding religious and spiritual issues, as well as their personal background and views in this area. Findings: 100% indicated they had received no education or training in religious or spiritual issues during their formal internship. Yet 72% reported that they had addressed those issues, at least occasionally, in clinical practice. This survey also revealed that most of the training directors did not read professional literature addressing religious and spiritual issues in treatment, and that little was being done at their internship sites to address these issues in clinical training.


Method: The authors designed a nationwide survey to assess the role of religion in psychiatric education. The questionnaire was distributed to the 1988 membership of the American Association of Directors of Psychiatric Residency Training (AADPRT). Of the 348 AADPRT members, 276 responded for a response rate of 79%. Findings: Results indicated that psychiatric educators do not emphasize religion in academic work: "Residents are rarely, if ever exposed to didactic course work on ally aspect of religion, including the use of religion as an
intrapsychic or interpersonal defense.” Whatever limited attention there was to religious experiences was largely confined to psychotherapy supervision. The authors concluded that, “An academic approach to the role of religion in psychiatry warrants consideration.” Suggested topics included: 1) religious experience on a continuum from unhealthy to healthy; 2) psychopathology expressed through religious content; 3) religion as a psychological defense; and 4) the role of religion in meeting psychological needs.

Thus psychologists and psychiatrists are often operating outside the boundaries of their professional competence, which raises ethical and educational concerns. Barnhouse has pointed out that, “Sex and religion are, in some form, universal components of human experience... Psychiatrists who know very little about religion would do well to study it” (Barnhouse, 1986, p. 103).

Despite these documented deficiencies in training regarding religious issues, considerable material on assessment techniques is available. The area of assessment is particularly critical for mental health professionals who must distinguish appropriate from pathological uses of religion. Barnhouse (1986) has pointed out that the pathological significance of religious language can seldom be determined by the immediate context alone. Knowledge of specific features of religious and spiritual belief systems is often essential in clinical decision-making, e.g., to assess assertions such as, "God spoke to me." This may, but does not necessarily, indicate the presence of a hallucination and/or a delusion: "If the patient is a lifelong member of a primitive fundamentalist sect, in the absence of other signs, it is safe to assume, at least provisionally, that he or she is not psychotic. Should a patient who is Roman Catholic ... report symptoms the same way, the index of suspicion of psychosis would be much higher" (Barnhouse, 1986, p. 100, emphasis in original). Lovinger (1984) has written about the profound differences in beliefs and practices among even the various denominations of Protestantism and how understanding these differences leads to better assessment and treatment.

Barnhouse (1986) suggests that a religious history be part of the standard evaluation, covering: 1) religion of family of origin; 2) how religion was practiced in the home; 3) if they have changed from their religion of childhood, abandoned religion altogether or taken it up for the first time; 4) how often they attend services; 5) do they find religion supportive, or frightening; 6) did they consult their pastor or rabbi about their problem and what he or she said; and 7) their idea of God. Salzman (1986) has also proposed assessment guidelines that can be used to evaluate the quality of the patient's relation to his or her religion. In addition, Pruysen (1984) has described eight religious pathological syndromes including demonic possession, scrupulosity, repetitive denominational shifting, and sudden conversion. Thus, despite the paucity of research,
clinical literature is available which contains guidelines for assessing religious issues.

Religion and Mental Health

In *DSM-Ill-R*, religion is consistently negatively portrayed. All the references to religion are in the context of psychopathology (Post, 1990). As noted earlier, when it is not being cast in a negative light, the topic of religion is generally ignored in psychiatric literature (Larson et al., 1986). In an invited address to the APA in 1986, the renowned theologian Hans Kung (1990) spoke about the "repression of religion" in psychiatric practice. This negative view of religion is not warranted based on some recent research. Many studies evaluating the relation between religiosity and mental health have yielded a significant and positive relationship between religiosity and psychological well-being.


Method: The author presents a meta-analysis of religiosity and mental health that challenges a widely held view in clinical professions that "religiosity is antithetical to emotional health and rationality." He examined 24 studies (1951-1979) with at least one religiosity measure and one clinical pathology measure. Findings: Of the 37 effects tabulated, only 23% showed a negative correlation between religion and mental health. In contrast, 47% showed a positive correlation and 30% no significant correlation. Thus 77% of the results were contrary to the postulated negative effect of religion. In addition, the author compares the ambiguous findings to those formerly characterizing psychotherapy research, and suggests that better specification of concepts and methods of measuring religiosity could alleviate these problems.


Method: In an effort to explore the relation between religion and subjective well-being in adulthood, the authors perform a quantitative research synthesis (meta-analysis) of U.S. research literature estimating the strength of the religion/subjective well-being relationship. Findings: Results indicate that religion is significantly and positively related to subjective well-being. The authors conclude that "religion should not, as has often occurred, be ignored in testing causal models of subjective well-being in adulthood."


Method: Using data from the 1983 and 1984 General Social Survey conducted by the National Opinion Research Center, the author uses...
regression analysis to examine the extent to which relationships with “divine others” affect psychological well-being (e.g., general well-being, general happiness, marital happiness, life excitement, and life satisfaction). Findings: Regression analysis (controlling for sociodemographic background variables and church attendance) revealed that relationships with "divine others" have a significant effect on several measures of well-being. In fact, participation in a divine relation was "the strongest correlate in three of four measures of well-being, surpassing in strength such usually potent predictors as race, sex, income, age, marital status, and church attendance."

In addition, studies have shown that while religiosity is associated with psychopathology among the clinical population, it is not among the nonclinical population.


Method: The relationship between religiosity and the incidence of schizotypal thinking was investigated in a normal sample and in acute and chronic schizophrenic samples. The Rust Inventory of Schizotypal Cognitions (measuring schizotypal thinking) was administered, along with two measures of religiosity. Findings: Religiosity had a significantly negative correlation with schizotypal thinking in normal subjects, while in schizophrenic patients the correlation was positive and significantly different. The authors suggest that "the process of existential growth of awareness in the normal development of religious belief, which is thought to be associated with schizotypal thinking, may proceed differently in persons suffering from schizophrenia."

In summary, available research has established religion's potential to foster positive mental health. However, its potential for preventing mental illness can only be inferred at this point. Longitudinal studies exploring the long-term effects of healthy religious development have yet to be conducted (Payne, Bergin, Bielema & Jenkins, 1991).

Treatment of Psychoreligious Problems

Religious issues are receiving more attention in the treatment literature, which documents that there is often therapeutic value in addressing a person's religious ideation (e.g., Bradford, 1985; Lovinger, 1984). A recent book (Winiaiski, 1991) devoted an entire chapter to the role of religion and spirituality in treatment. In that chapter, the author noted: "Facing the mystery and suffering of HIV illness, both client and therapist may turn to religion, spirituality, and concepts of God in their efforts to find solace, understanding, and emotional healing" (p. 183). Although the role of religion in therapy has been acknowledged since Jung, little is known of the dynamics and effective
components involved. One behavioral therapist, discussing a documented case of a transsexual who showed a dramatic and complete reversal after only two sessions of faith healing (versus the generally poor results of behavior therapy with such cases), observed that:

The speed and durability of these faith healing cures leaves behavioral and other forms of psychotherapy far behind in terms of cost-effectiveness. The problem is repeatability... When it works, faith healing has a power far surpassing existing psychotherapy technology. The order of magnitude of this difference is like that between nuclear and more conventional explosives. But we have not yet harnessed nuclear power satisfactorily, and our understanding of faith and religious processes is far more primitive than our knowledge of subatomic particles (Issac Marks, cited in Tan, 1990, p. 60).

Below are abstracts of research articles which address the role of religion in treatment.


*Method:* This study, which is frequently cited by Bernie Siegel, M.D., evaluated the effects of intercessory prayer (IP) in a coronary care unit using a prospective randomized double-blind protocol. Over a 10-month period, 393 patients admitted to the CCU at San Francisco General Hospital were randomly assigned (after giving informed consent) to an IP group or a control group. The IP group received IP by participating Christians praying outside the hospital; the control group did not. **Findings:** "The IP group subsequently had a significantly lower severity score based on the hospital course after entry (p<.01).... The control patients required ventilatory assistance, antibiotics, and diuretics more frequently than patients in the IP group. These data suggest that intercessory prayer to the Judaeo-Christian God has a beneficial therapeutic effect in patients admitted to a CCU."


*Method:* This study compared the relative therapeutic efficacy of a religious and a nonreligious imagery modification, a self-monitoring, and a self-monitoring plus therapist contact program for university students who scored high on the Beck Depression Inventory and a scale of religiosity. The religious imagery used to modify depressive images included self-statements such as: "I can visualize Christ going with me into that difficult situation in the future as I try to cope." **Findings:** "The nonreligious imagery treatment showed no effects beyond those of the self-monitoring treatment or the minimal treatment condition. The religious imagery treatment, however, showed significantly more treatment gains than the self-monitoring or nonreligious imagery treatments."

**Method:** The authors, a psychiatrist and a chaplain at a Veteran's Administration medical center, report on a program which adapted the AA Twelve Step program for the treatment of post-traumatic stress disorder (PTSD). They incorporated AA principles including depending on a Higher Power, viewing recovery as a process rather than a cure, and the interdependency of group members. However, the principles were adapted for veterans coping with guilt and other problems related to combat survivors. Thus Principle 9 read: "We reveal to someone we trust and a 'Good Higher Power' all suicidal plans and wishes and seek, with help, to replace them with a commitment to life."

**Findings:** The authors report that participants were able to reduce their violent urges, their self-destructive behaviors, and their guilt, while enhancing the positive aspects of their self-identities. Krippner and Welch (1992) cites a personal communication indicating that the Veteran's Administration terminated the program because of their incorporation of a spiritual focus in the treatment, despite the positive effects being obtained.


**Method:** The empirical research on religious counseling from 1974-1984 was reviewed by examining the table of contents of twenty journals which publish on this topic. Research was scattered throughout the psychology, psychiatric, pastoral counseling and religious journals. Although an effort was made to examine published research on religious counseling in all religions, most research used Christian counselors or clients. **Findings:** "Clergy do most of the religious counseling," and "Clergy counsel people with the full range of psychological difficulties." Problems concerned specifically with religion, such as loss of faith, were encountered relatively infrequently in comparison with family problems. Clients who seek help from clergy are not more disturbed than those who seek out mental health professionals, but "expressed concern that their Christian faith would be misunderstood, unappreciated, or perhaps even ridiculed or eroded by an agnostic or atheistic counselor."


**Method:** 1045 research articles published in major pastoral counseling journals were compared with research articles in four major psychiatric journals and three geriatric journals. The degree of internal and external validity was assessed by examining their design, sampling, measures and statistical procedures according to operational criteria. **Findings:** In comparison with studies reported in psychiatry, geriatric and nursing journals, "pastoral counseling research is less likely to
state hypotheses, to use control groups, to state a sampling method, to report a response rate, to evaluate more than a simple point in time, or to discuss limitations of the findings." The authors maintain that, given these factors, pastoral counseling has failed to develop adequately as a behavioral science. One respondent argued that pastoral psychology is an interdisciplinary field, and quantitative methods are not the best suited to explore this area: "If our efforts in pastoral psychology and its clinical application are understood as a hermeneutical science, then we are freer to explore different research methodologies which may more clearly address the research needs of this discipline within its own parameters."


Method: The authors sent a survey to 260 psychiatrists who were members of the Christian Medical and Dental Society. One hundred ninety-three usable responses were received. Members of this group must sign a statement acknowledging "the final authority of the Bible as the word of God." Findings: The items adapted from Gallup surveys revealed that these psychiatrists were a little more religious than the general population, and considerably more religious than most psychiatrists. Ninety-eight percent said they believe in the Devil (vs. 70% of the general population), and 96% said they had been born again (vs. 40% of the general population). Christian psychiatrists stated that they varied their treatment depending on whether the client was committed to Christian beliefs: 1/2 would use prayer with committed clients and only 1/5 with noncommitted. For acute schizophrenic and manic episodes, medication was reported the intervention of choice, but for suicidal intent, grief reaction, sociopathy, and alcoholism, the Bible and prayer scored as the most effective modality.

STUDIES OF THE PSYCHORELIGIOUS/PSYCHOSPIRITUAL DIMENSIONS OF HEALING

The topics of addiction, ethnic perspectives, terminal illness, and mystical experience straddle the religious and spiritual arenas. In some cases, the problems and the treatments associated with these phenomena are clearly associated with religious beliefs and organizations. In others, the focus is spiritual: "state of awareness or devotion to a higher being or life philosophy" (Walker, 1991), and not related to conventional religious beliefs. We have included the areas of addiction and ethnic perspectives in this review because the bulk of the addiction research articles uncovered in our search focused more on the psychoreligious aspects of healing. In contrast, the research articles on terminal illness and mystical experience were more spiritually oriented, and thus will be included in the next planned review on the psychospiritual dimensions of healing. However, since the topics of addiction and ethnic perspectives inherently involve psychospiritual dimensions as well as psychoreligious, the term spiritual is often used by the original authors in
Addiction

Numerous studies have found that alcohol and drug abuse are negatively related to religiosity. In particular, substance abuse is associated with the absence of religion in a person's life (for a review of this literature, see Payne, Bergin, Bielema & Jenkins, 1991). It is therefore not surprising that many of the treatment programs have characteristics of religious groups. Alcoholics Anonymous (AA), the most popular self-help group for alcoholics, has been described as a pseudo-religion, mystical religion, self-help group, minority movement, Messianic movement, and/or crisis curing cult (Bufe, 1991; Madsen, 1974). Estimates of membership in AA range from 750,000 to 2,000,000 spread over a hundred countries, and offshoots of AA have been developed for other addictive behaviors, including Narcotics Anonymous, Cocaine Anonymous and Marijuana Anonymous (Bufe, 1991). Twelve Step Programs purport not to have a religion, but rather a spiritual orientation. In the AA program, one step mentions "A Power greater than ourselves" and the final step mentions a "spiritual awakening." However, five of the Twelve Steps make a specific reference to God, and the phrase "as we understand Him" appears twice. The founders of AA did not ponder whether religious and spiritual factors are important in recovery, but rather if it is possible for alcoholics to recover without the help of a higher power (Miller, 1990).

Researchers have been reluctant to study AA itself, possibly because of its reliance on religion and spirituality, its voluntary nature (making it impossible to randomly assign subjects), as well as AA's own resistance to exposing its members to scrutiny due to the possible loss of anonymity. Twelve Step programs are widely, although not universally (Ellis & Schoenfeld, 1990), regarded as the most effective approach to the treatment of addictions. While the research on its effectiveness, as reviewed below, is equivocal, surveys of drinking histories of members. case studies, and AA's many adherents are all highly suggestive that at least some people benefit from this approach.

Method: The author reviews empirical, historical, clinical, legal, and other literature to present a perspective largely critical of AA. Findings: AA's founders were active members of the evangelical Christian Oxford groups in the 1930s, and the profound similarities between AA and these religious groups are documented. Hence, the author argues that AA is "unequivocally" religious in nature. Bufe also systematically considers the question of whether AA is a cult, concluding that it is not: "AA has neither a charismatic leader nor an authoritarian hierarchy. It doesn't exploit its members. It doesn't employ mind-control techniques... It doesn't use deceptive recruiting techniques." However, he argues that "it does have some dangerous cult-like tendencies." With regard to its effectiveness, the author concludes that, based on the available outcome studies, it is an appropriate treatment method for some, but "clearly AA is neither a suitable nor an effective form of treatment for the vast majority of alcohol abusers."


Method: The author reviewed all published studies from 1976-1986 of the characteristics of alcohol dependent individuals who affiliate with AA. Findings: Research failed to isolate an "AA personality," with studies finding no or inconsistent differences between AA and non-AA members. Most studies (54%) have found that attending AA before, during or after treatment was positively related to treatment outcome. Two studies have found that membership in AA was the most powerful predictor of positive outcome, although 36% found no relationship between AA membership and outcome. A large percentage (35-68%) drop out of AA, although 40-50% become long-term active members. Sixty-eight percent of active members drink less or not at all during AA participation. The author concludes that: "AA is helpful for some individuals, but treaters are on unethical ground when they insist rigidly on exposing every patient to large 'doses' of AA."


Method: The author conducted a literature review of published research on addiction. He uses "spiritual" to encompass both religious and spiritual variables. Findings: "Spiritual aspects of addiction and recovery remain virtually unstudied, despite the fact that spirituality is given central importance in Alcoholics Anonymous and in the lives of many individuals. ... Consequently an entire class of potentially important variables is being overlooked." The use of dependent (e.g., measures of perceived purpose or meaning in life, changes in values and beliefs, shifts in religious practices), moderator (e.g., relationship of clients' religious value systems and acceptance of particular treatment goals and strategies), and independent spiritual variables (e.g., the impact of spiritually-oriented interventions on treatment outcome) in research "may improve our understanding of the addictive behaviors, and our ability to prevent and treat these enduring problems." The
contemporary biopsychosocial perspective of psychology and psychiatry needs to be expanded to include the transcendent dimensions of experience.

**Ethnic Perspectives**

The need for "cultural sensitivity" in mental health practice has been a topic of much debate in the recent psychiatric literature (Fabrega, 1992; Kirmayer, 1991; Kleinman, 1988; Mezzich, Fabrega & Kleinman, 1992). The religious and spiritual dimensions of culture are among the most important factors which structure human *experience*, beliefs, values, and behavior, as well as illness patterns (Browning, Gobe & Evison, 1990; James, 1961; Krippner & Welch, 1992). The abstracts below illustrate that cultural sensitivity requires attending both to ethnic as well as religious dimensions of clients’ problems. While this first abstract involves the treatment of addiction, it emphasizes an ethnic perspective, so it was placed in this section.


**Method:** The Indian Shaker Church is a century-old inter-tribal religious movement and curing cult. To study its function as a culture-based alcoholism intervention, the authors conducted interviews in New Mexico, Arizona, and northern California with 14 traditional religious healers and 57 alcohol treatment personnel, as well as taking drinking histories from 53 area Indians and 87 northern California Shakers. Participant observation of Shaker work included one author becoming a member of a Shaker curing team. **Findings:** The authors found that many socio-cultural elements are held in common by AA and the Shaker Church: "These parallels include an antecedent period of social upheaval, the visionary impetus of the conversion of a focal charismatic leader, the primacy of the conversion experience, cult institutionalization through formulation of charter myths, codified doctrines, sacred texts, standardized rituals and paraphernalia, and ongoing membership in social support networks." In addition to these shared elements, a number of culture-specific indigenous curing procedures distinguish the Shaker Church from AA and other conventional alcohol recovery programs: 1) the belief that alcoholism can be a product of sorcery or demonic activity; 2) and the focus on diagnosing the problem through seeing of colors and auras.


**Method:** Members of a West Indian Christian sect called the Spiritual Baptists participate in a "mourning" ritual that is characterized by praying, fasting, and the experiencing of dreams and visions while in
isolation for seven days. Sixteen individuals who underwent mourning were evaluated with the SCL-90 (a well-known self-report questionnaire) before and after the ritual, in order to document changes in psychological symptoms related to this mourning ritual. **Findings:** While there was no significant change on the somatization dimension, the participants scored significantly lower on obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, paranoid ideation, and psychoticism. There were significant reductions in the global severity index and the positive symptom total. The authors concluded that "the results of this study raise for the first time the intriguing possibility that such religious practices have an effect that can be characterized psychometrically. This possibility merits the replication of this work with a larger group of subjects together with investigation of the notion that these practices may have long-term effects."


**Method:** The author based his conclusions on clinical work as well as research interviews with Cambodian refugees. **Findings:** Cambodian refugees often show signs of distress which are not related to acculturation difficulties, but reflect an understandable response to the catastrophic loss of their culture: "the person continues to live in the past, is visited by supernatural forces while asleep or awake, suffers feelings of guilt, yearns to complete obligations to the dead, and feels stricken by anxieties, morbid thoughts, and anger that mar the ability to get on with daily life." Given their experience of being uprooted under such violent circumstances, these reactions "may be a normal, even constructive, existential response, rather than a psychiatric illness." Eisenbruch argues that adding cultural bereavement to the nosology would refine the diagnosis of post-traumatic stress disorder and would allow for greater recognition of the refugee's existential predicament. Western medical intervention may only compound the refugee's distress and inhibit healthy aspects of the cultural bereavement process. However, intervention by a Buddhist monk or traditional healer may successfully restore the patient's link with the past and help reintegration into the community.

This last abstract illustrates the role which the organized religion of Buddhism sometimes plays in treatment of Asian clients.

**CONCLUSION**

As with the topics covered in previous Research Reviews (i.e., mystical experiences [Lukoff & Lu, 1988] and psychoactive substance-induced experiences [Lukoff, Zanger & Lu, 1990]), psychoreligious problems are difficult to research within the standard experimental scientific paradigm. But, as Walsh (1982) has pointed out:
It is the responsibility of science to confront all areas of knowledge irrespective of the difficulty involved, and not to shirk investigation because the areas in question do not lend themselves to the best-honed experimental tools presently at hand (p. 165).

Similarly, on the clinical level, it is often hard to differentiate religious experiences from episodes of mental disorder (Lukoff, 1985). Yet, as Gabbard, Twemlow & Jones (1982) have pointed out, mental health professionals are often entrusted with the responsibility of differentiating unusual from psychopathological experiences:

It is incumbent upon us as psychiatrists to be thoroughly familiar with the range and breadth of human experience, whether pathological or healthy. We must respect and differentiate unusual but integrating experiences from those which are distressing and disorganizing (p. 368).

The authors believe that greater attention to the psychoreligious dimensions of healing would improve clinical practice by: 1) encouraging research on religious issues in psychotherapy; 2) increasing the accuracy of diagnostic assessments when religious issues are involved; 3) reducing the occurrence of iatrogenic harm from misdiagnosis of psychoreligious problems; 4) improving treatment methods for such problems by stimulating clinical research; and 5) encouraging clinical training centers to address the religious dimensions of human experience. Similar advantages would accrue when the psychospiritual dimensions of healing are explored. This will be the topic of our next Research Review.

REFERENCES


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