

Differential diagnosis of “Religious or Spiritual Problem” – possibilities and limitations implied by the V-code 62.89 in DSM-5

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Summary

Introduction. Work over preparation of DSM-5 has been a stimulus for research and reflection over the impact of religious/spiritual factors on phenomenology, differential diagnosis, course, outcome and prognosis of mental disorders.

Aim. The aim of this paper is to present the attitude of DSM towards religion and spirituality in the clinical context. Even though DSM is not in use in Poland, in contrast to ICD, it gives a different, not only psychopathological, look at religious or spiritual problems.

Methods. The paper is based on in-depth analysis of V-code 62.89 (“Religious or spiritual problem”) from historical, theoretical and clinical perspective.

Results. The introduction of non-reductive approach to religious and spiritual problems to DSM can be considered as a manifestation of the development of this psychiatric classification with regard to the differential diagnosis between religion and spirituality and psychopathology. By placing religion and spirituality mainly in the category of culture, the authors of DSM-5 have established their solution to the age-old debate concerning the significance of religion/spirituality in clinical practice. Even though, DSM-5 offers an expanded understanding of culture and its impact on diagnosis, the V-code 62.89 needs to be improved taking into account some limitations of DSM classification.

Conclusions. The development of DSM, from its fourth edition, brought a change into the approach towards religion and spirituality in the context of clinical diagnosis. Introducing V-code 62.89 has increased the possibility of differential diagnosis between religion/spirituality and health/psychopathology. The emphasis on manifestation of cultural diversity has enabled non-reductive and non-pathologising insight into the problems of religious and spirituality. On the other hand, medicalisation and psychiatrisation of various existential problems, which can be seen in subsequent editions of the DSM, encourages pathologising

approach towards religious or spiritual problems. Clinical look at religion and spirituality should therefore go beyond the limitations of DSM.

Key words: DSM-5, religion and spirituality, differential diagnosis

Introduction

Relationships between religion and spirituality – on the one hand – and mental health and psychopathology, on the other, are discussed in the professional literature from historical, speculative-empirical and clinical perspectives. Within the confines of this last approach “religious” case studies are analysed and religious and spiritual factors are debated on a phenomenology, differential diagnosis, course, ceasing and perspective of treatment of mental disorders. Generally speaking, the term “spirituality” refers to the experience of the transcendent as well as ways of understanding God and other forces in the universe. “Religion” is understood as the institutionalised system of beliefs, values and actions based on its credo (dogmas) [1, 2]. In this paper the place and significance of religion and spirituality in the classifications of mental disorders and their use for differential diagnosis will be analysed.

In regard to the psychopathology of mental disorders, there are two basic classifications: the first one was created by the American Psychiatric Association (Diagnostic and Statistical Manual of Mental Disorders – DSM) and the second one was published by the World Health Organisation – WHO (The International Statistical Classification of Diseases and Related Health Problems – ICD). The first version of DSM was written in 1952 and included 106 disorders. DSM-II was developed in 1968 and contained 128 disorders. DSM-III was published in 1980 and consisted of 265 diseases. DSM-IV was announced in 1994 and listed 297 disorders. The latest version of DSM-5 was released on 18th May 2013, after 14 years of work, and replaced DSM-IV-TR created in 2000. In many aspects, DSM-5 does not differ significantly from the previous version [3]. In the US, insurance companies consider both DSM and ICD to be valid, but the majority of psychiatric institutions and professional associations recommend DSM as more nuanced and versatile. It is believed that, as a phenomenological system, DSM allows clinicians of different theoretical orientations to communicate successfully. So the dominant tendency is for diagnostic criteria, treatment recommendations and payments made by health care providers to be determined on the basis of this classification [3, 4].

In their diagnosis of mental disorders, most psychiatrists and clinical psychologists use the tenth edition of ICD (ICD-10), in which mental disorders appeared for the first time in the history of this classification (WHO, 1992). In September 2009 the first version of ICD-11 was issued, whereas the final version was to be published in 2015. At the moment, the time limit has been postponed until 2017. The analysis of the first version of ICD-11 indicates that, compared to ICD-10, it will not undergo major changes. Comparing DSM and ICD, both psychiatrists [5] and clinical psychologists [3] point out that there are relatively small differences between them, and in recent editions of classifications one can notice a clear trend towards unification. When talking about the existing discrepancies, they point to the fact that DSM focuses more

on axial symptoms and attempts to make the division lead to practical guidelines for diagnosis, diagnostic criteria and treatment. ICD is, however, more complex. The main criterion of division in this classification is the aetiology of disorders rather than their clinical picture.

Religion and spirituality in clinical context

Research shows that psychological support is most effective when it is adapted to the characteristics of a particular person, including his or her worldview, values, spirituality and religiosity [6, 7]. Studies have shown [8] that a lot of people who have undergone traumatic experiences are seeking help in spirituality, seeing it as an important resource. Positive ways of coping with problems (e.g. by developing a supportive relationship with God, seeking spiritual relationships and support) correlated with improved mental health and increased posttraumatic growth. The fact of taking into account the spiritual and religious issues in psychotherapy and their proper diagnosis are particularly evident in the work with so-called “religious patients”, who often anticipate the negative attitude of the therapist to their religion, expecting a rejection of their religious beliefs, and prefer to seek help in the place where they feel understood and accepted [9]. Also, psychiatric patients often refer to some kind of religious beliefs and practices in order to help themselves. It has been noted, however, that in the case of many of the mentally ill, their religiosity or spirituality is a priori considered as a symptom of a disease. In addition, the negative attitudes of psychiatrists or psychotherapists have often resulted in the patients’ withdrawal into themselves and their decision not to disclose spiritual experiences, questions or concerns [10].

On the other hand, research involving students shows that their problems are often associated with religious or spiritual issues. In psychological literature, religious and spiritual problems are usually connected with interpersonal and intrapsychic struggles as well as struggles with God. Interpersonal struggles are related to conflicts which concern spiritual or religious values and which occur between the individual and the person or persons in his/her social or religious environment. Internal struggles may refer to conflicts between the declared values and one’s needs and may involve guilt, anxiety and low self-esteem. Struggles with God relate to the feeling of loss of contact with this reality, a sense of rejection or, because of that, loss of the meaning of one’s own life [11]. Large surveys covering 5,472 male and female students found out that nearly one third of them were seeking psychological help in clinics operating at universities because of the distress arising from their struggle with religious or spiritual problems. Researchers observed that students with religious and/or spiritual problems were almost twice more likely to have difficulties in defining their values and beliefs than students whose problems were not the result of their struggle with religious or spiritual problems. It also turned out that students with religious and/or religious concerns were more often victims of sexual abuse, unhappy separations, conflicts with peers; they were more prone to suicidal thoughts and worse relationships with their families. These studies show that for some people the area of religion or spirituality is a significant source of stress. According to the authors of these studies, the question

concerning the religious or spiritual history of a patient/client should become a routine diagnostic activity [12]. Obviously there are many more clinical populations where religion and spirituality impact on phenomenology, course, ceasing and perspective of treatment of mental disorders has been demonstrated [13].

Public opinion polls show that people are increasingly giving a positive answer to the question “Have you ever been aware of or influenced by the presence or force – referred to as God or otherwise – which is different from your usual self?” In 1973 there were 27% of such people, in 1986 – 42%, in 1990 – 54% and in 2001 – 70%. A similar increase in affirmative answers can be seen in case of questions about paranormal experiences (e.g. 35% of respondents said that they had had a near-death experience). These experiences were described as positive, but the respondents admitted that they are afraid of disclosing them because they assumed that no one would understand them or, what is worse, they would be regarded as insane [14]. In one study, psychologists indicated that 4.5% of their clients/patients told them about the mystical experience they had undergone over the last twelve months [15].

However, studies [16, 17] show that clinicians make diagnostic evaluation of the patients with religious/spiritual experiences primarily on the basis of their own cultural norms. The more unusual (or unsuitable for their understanding of spirituality or religion) the cases analysed by them were, the more often they interpreted them in terms of psychopathology. Although most of them did not perceive mystical experiences as a sign of psychosis, some of them thought such clients were “potentially psychotic” regardless of information provided to them. Others, in turn, did not see obvious signs of psychosis – such as impaired cognition and strange behaviour – and diagnosed such clients as “probably non-psychotic”, no matter how psychotic their thinking and behaviour were.

The guidelines of the American Psychiatric Association [18] and American Psychological Association [19] require clinicians to formulate a differential diagnosis between religious or spiritual problems unrelated to mental disorders and those that either co-occur with symptoms of such disorders (but with no causal relationship) or are factors which trigger or support an individual pathology. In each of these cases, the V-code 62.89 can be used and included in the diagnosis either (a) independently, (b) next to the diagnosis of a mental disorder or (c) within the diagnosis of the disorder if its symptoms have a religious or spiritual content. This clinical approach corresponds to the results of research into the links between religion/spirituality and mental health/psychopathology [20–22].

In the first case, religion/spirituality has a positive (salutogenic) function – it helps people to find better ways of functioning in the world. In the second case, it becomes an expression of different forms of thinking and behaviour, which either control or inhibit the individual’s own thinking and behaviour. This happens when deviant forms of thinking and behaving gain social acceptance, occurring in a religious context, or when religion/spirituality provides effective mechanisms for escape and creates favorable conditions for avoiding the difficulties of real life, which man cannot fully deal with on his own. Then it assumes the patoplastic role. Finally, religion/spirituality can exercise an effect of stress on human beings by either deepening their weaknesses

or leading to the occurrence of serious forms of maladjustment. This is called the pathogenic function [23].

Differential diagnosis based on the V-code 62.89

In contrast to ICD-10, which places states of trance only in the context of psychopathologies (F44.3) previously known as hysteria, DSM-IV and DSM-5, which were introduced after it, allow treatment of trance states as manifestations of religious and/or spiritual problems and give the possibility to diagnose them as “Conditions that may be a focus of clinical attention”. In contrast to ICD-10, among the V-codes of DSM-IV including “Other conditions that may be a focus of clinical attention”, which are analogous to the Z-codes in ICD-10 (“Factors influencing health status and contact with health services”), there is a code directly related to religion and spirituality called “Religious or spiritual problem” (V 62.89), which is part of “Other conditions that may be a focus of clinical attention”. In ICD-10, as part of the Z-codes, such a diagnosis can be taken into account only within the default Z-code 71.8 (“Other specified counseling”) [24] or the Z-code 65.8 (“Other Specified Problems Related to Psychosocial Circumstances”) [25].

The DSM-5 section devoted to “Other conditions that may be a focus of clinical attention” has been greatly expanded and in this edition the V-code 62.89 starts the list of issues connected with “Problems related to other psychosocial, personal and environmental circumstances.” However, similarly to DSM-IV and DSM-IV-TR, the content of the V-code 62.89 has not changed:

V 62.89 (Z 65.8). 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 spiritual values that may not necessarily be related to an organized church or religious institution [26].

DSM therefore assumes that religion is a part of culture, and the inclusion of religion and/or spirituality in psychotherapy may belong to the patient’s preferences. In addition, clinicians are ethically obliged to assist the patient in such a way which takes into account the cultural and religious context [27, 28]. Unlike previous versions, however, DSM-5 does not only have an extensive section devoted to cultural aspects of diagnosis (“Outline for Cultural Formulation”), but also includes a new diagnostic tool called Cultural Formulation Interview (CFI), which can be used not only to identify religious and spiritual problems corresponding or not with the cultural concepts of distress, but can be implemented in the assessment of an individual’s religion or spirituality regarded as a tool for coping with psychosocial stressors.

According to the assumptions of the symptomatologically oriented medical model adopted in DSM-5, the diagnosis of the patient’s religion or spirituality takes place when they are regarded as causing problems in his or her functioning. Spirituality or religiosity is taken into consideration especially when it is problematic – as a result of the very conceptualisation of V-codes. As it was written in the book acclaimed in the US and serving as an introduction to DSM-IV, called “DSM-IV Training Guide”: “V

codes are not indicators of mental disorders, but should be taken into account when dealing with the problems that result in clinically important symptoms or difficulties in functioning. They may worsen the existing disorder, or impede their treatment” [29].

Besides, DSM-5 authors emphasize that: “some of the clinical conditions identified by CFI may correspond with V or Z codes, e.g. problems of acculturation, relational problems between parents and children, religious or spiritual problems” [26].

Thus, the V-code 62.89 focuses on those critical situations which are sudden and represent short answers to specific religious or spiritual issues such as trauma, family and relational problems, disappointment with the Church, the fact of changing one’s beliefs or religion, loss, physical illness, religious burnout, conflict of conscience, identity crisis [30]. The originators of the code entitled “Religious or spiritual problem” emphasise in turn the importance of including within this code such anomalous experiences as: peak experiences, near-death experiences, the state of being possessed by devil forces, experience of previous incarnations, experience of being kidnapped by a foreign power, contacts with spirits or a psychic, psi experience, awakening of the kundalini, shamanic crises, intense experiences connected with meditation or other spiritual practices. They divided those experiences into two “main” groups. In the first group there were crises associated with a change in consciousness, whereas the second one included those experiences which led to the opening up of a person onto more subtle or more psychological dimensions of reality – although elements of each of them could be present in most sudden spiritual crises. The distinguishing feature of them all was the fact that despite the suffering they caused, they had a positive, i.e. transforming impact on the personal and spiritual development [31].

In the specialist literature there are different definitions of anomalous experiences, but their common feature is that they differ from ordinary experience or commonly accepted explanations of reality [32]. Psychiatrists and psychologists who have developed the outline of the V-code 62.89 consider these anomalous experiences as manifestations of “spiritual emergencies.” They are either not strong enough or culturally incomprehensible – which means they are not commonly known but familiar for subcultures – to be defined as mental disorders. They usually appear as a result of a stronger commitment to spiritual practices, which can lead to “psychological overdrive”, which is not, however, a sign of psychopathology [31]. Attention is frequently drawn to the fact that especially two types of religious and/or spiritual experiences should be distinguished from mental disorders: (a) mystical visions and voices from psychosis, (b) “the dark night of the soul” from clinical depression [30, 33].

However, studies on the clinical use of the V-code 62.89 brought mixed results. In the group of 258 psychologists, 44.7% were familiar with the code identified as “Religious or spiritual problem”, but the majority, i.e. 55.3%, were not. In the first group, 11.2% said they had used this diagnosis over the past year, whereas 19.2% said they had used it earlier [34]. In another study [35], in which 333 psychologists participated, 6.2% of them had used the V-code 62.89 as part of their diagnosis. Most of psychologists (4.5%), had done it in the context of their private practice, the rest had employed it in mental health facilities associated with the military. The study involving a group of 100 psychologists (60 women and 40 men, 84% of whom had a private pra-

ctice) showed that these psychologists believed this code to be clinically helpful. 65% said they would use it more often but the problem is with insurance companies, which did not refund the costs of such treatments [36]. Apart from “practical” obstacles and the fact that the clinician using DSM has no obligation, in the formal diagnosis, to go beyond first three axes in the evaluation of the patient/client, an adequate understanding of religion and spirituality in the context of diagnosis and treatment is hampered by the very idea of nosological classification and the structure of DSM.

Recapitulation

Looking at the history of relationship between religion/spirituality and mental health/psychopathology through the lens of the clinical classification on mental disorders we can say that they reflected following trends among clinicians: (a) religion and/or spirituality were not essential for the psychotherapy, (b) they were important manifestations of life but unconnected with psychiatry, (c) therapists were not trained to deal with those issues or even asked questions about them, (d) those concepts as such did not have any precise meaning, and it was in good taste to avoid them in research and clinical practice, (e) there was also a “religious gap” between the general public and clinicians, who rarely see themselves as believers. Thus, it can be said that the reasons behind such separation of religion/spirituality in another editions of DSM and ICD were personal and institutional considerations. In some cases, the lack of knowledge about religion/spirituality resulted from the lack of personal interest in them – so it was easier to ignore these issues rather than explore them. In others, it was believed that there was a clear line of competence in this matter between clinicians and clergy [37, 38].

Until the emergence of DSM-IV, in its earlier versions, and in the ICD, religious and spiritual experiences only as causes of the patient’s psychopathology or its symptomatological expression, whereas religion and spirituality were over-represented in the examples designed to illustrate psychopathology. The positive (adaptive) role of religion in human mental functioning was minimized or negated [39]. A new look at those issues is brought by the fourth edition of DSM, in which more space is devoted to the cultural aspects of mental disorders through the development of “The glossary of culture-bound symptoms” and “Outline for cultural formulation.” It was also taken into consideration that religion and spirituality is not the same thing – although one may include the other and vice versa – and can variously affect the functioning of man.

The fact of paying more attention to the cultural conditions of clinical diagnosis, a high frequency of religious and spiritual experiences in the general population (an average of 35%) and greater empirical knowledge about the complexity of the impact of religion/spirituality on mental health which indicate that (a) religiosity/spirituality may be part of the solution of psychological problems, (b) religiosity/spirituality may be itself a source of problems, (c) people expect to be helped in a way which takes account of their faith or spirituality, (d) elimination of religion and spirituality from the therapy may result in low effectiveness of the treatment meant that religion and spirituality ceased to be the “taboo” of psychotherapy. This new, non-reductionist and non-pathologising attitude towards religion and spirituality in the context of a clinical

diagnosis was adopted in the code entitled “Religious or spiritual problem” and could be seen in the greater sensitivity of DSM to manifestations of cultural diversity. Even though, one can notice a clear trend towards unification in recent editions of classifications of DSM and ICD, it can be said, however, that there is a clear difference between them when it comes to the assessment of religion and spirituality in the clinical context, since only DSM has a diagnostic code directly dealing with religious and spiritual problems, and allowing for a differential diagnosis.

It seems that by situating religion and spirituality mainly within the scope of „culture”, the authors of DSM-5 pointed to the place which those concepts can occupy in psychiatry without the risk of clinicians being accused of medical reductionism, hostility or silence in relation to these manifestations of human existence [25]. Since the emergence of this new diagnostic code it can also be observed that there has been a significant increase in interest in the study of religion and spirituality in psychotherapy, as well as in training of psychiatrists and clinical psychologists in this domain [19, 40–44]. This trend also begins to be visible in Poland, where in addition to academic [20, 45, 46] and popular scientific [47, 48] publications, topics related to religion and spirituality appear at conferences organized by sections of psychotherapy divisions of the Polish Psychiatric and Psychological Association, and also as part of some training courses qualifying for the profession of a psychotherapist. At present, one can observe the following tendency: psychotherapists are less religious (and more spiritual) than their patients/clients, although most of them perceive religion as the element which supports development and adaptation, rather than limits them [49].

Although there is positive change in psychiatry towards religion and spirituality, that can be seen in appearance of V-code 62.89 in DSM classification, the key idea behind the creation of such classifications leads to the “invention” of new clinical entities, as well as medicalization and psychiatrization of the problems or experiences so far regarded as existential [50], religious or spiritual [51]. This trend is evident both in increasing of new diagnosis and overrepresentation of some of them (for example, the autistic spectrum disorders boost 600% between 1990 and 2006) and is accompanying by turning from categories to dimensions, where the risk/disposition assessment becomes a clinical diagnosis itself.

Similar tendency is seen among psychiatrists and psychologists working on the preparation of DSM-5 in terms of religious and spiritual issues in clinical diagnosis who mainly emphasize the need to expand the definition of the V-code 62.89 to other types of religious and spiritual experiences and broaden the list of issues relating to religion and spirituality [13]. Although these efforts are meant to increase the reliability of the differential diagnosis made on the basis of DSM, they leave a number of unresolved issues concerning, the definition of “religious hallucinations and delusions” and the existence of religious/spiritual experiences bordering on psychosis, which resemble, in their form and content, psychotic symptoms with religious and mythological overtones (hallucinations and delusions), but have different effects. As it is demonstrated by the research into the so-called “spiritual-psychotic paradox”, such experiences cannot be distinguished from one another by means of standardized clinical tools referenced in DSM or ICD [53].

It seems problematic to postulate, as they do, the introduction to DSM, and more specifically to the V-code 62.89, of a new clinical entity: “Mystical experience with psychotic features”, which is meant to resolve the spiritual-psychotic paradox in the differential diagnosis [54]. Similar problems are posed by the medicalization of melancholy [55]. Reserach shows that, of all psychiatric disorders, depressive mood disorders are most closely correlated with spiritual experiences along the entire spectrum of symptoms. Mild symptoms of depression are often regarded as signs of spiritual development in most spiritual traditions, whereas its clinical symptoms are sometimes associated with the occurrence and solution of a spiritual crisis. Besides, religion and spirituality are often seen as means of protection against depression or means of mitigating its symptoms [56].

The fifth edition of DSM was severely criticized because of the fact that many changes introduced in it lack an empirical base, whereas several fragments are badly written and incomprehensible. 13,000 doctors, organizations and foundations catering to the needs of the mentally ill have signed a petition seeking radical changes in DSM-5 [3, 5, 57]. The amended version, however, has not been published yet. It is therefore important to emphasize the importance of the clinician’s (therapist’s) self-awareness in terms of his personal spiritual beliefs and attitude to religiosity. This awareness helps to avoid negative effects of the “ideological countertransference” [58] and to truly respect beliefs, values and experiences of the patient/client. Because a few lines in DSM concerning religion and spirituality neither reflect the complexity of both of them nor matches difficulties in distinguishing psychic and spiritual dimensions of human behavior in clinical context (see [59–63]). Going beyond the DSM is not enough for integration of religion and spirituality into psychotherapy. This integration is not arbitrary and value-free enterprise, but is still possible without obscuring or crossing boundaries of psychotherapy and spiritual direction.

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