

“Gambling with God:” A Self-Inflicted Gunshot Wound with Religious Motivation in the
Context of a Mixed-Mood Episode

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[1] CASE HISTORY

[2] Presenting Problem

This 55-year-old married father of two adult children, with a history of major depressive disorder and alcohol use disorder in remission, presented to the medical hospital for two self-inflicted gunshot wounds (GSWs) in the span of one year. Mr. W described his second self-inflicted GSW as an attempt to end his life. His case is unusual in that he described his first self-inflicted GSW not as a suicide attempt but rather as an attempt to test God;¹ the setting was a mixed-mood episode coupled with his increased contemplation of God, with the latter prompted by attending Alcoholics Anonymous (AA) meetings.

[2] Developmental and Social History

Mr. W was an only child born and raised in Massachusetts. His mother worked as a secretary, and his father in the restaurant business. The patient reported feeling he was spoiled as a child and rarely punished for bad behavior, which he felt had led to a warped sense of responsibility and a failure to realize that his actions had consequences. He observed that his parents had been loving, though he also noted feeling lonely as a child, as both of his parents worked and he had no siblings.

He reported having had difficulty with intimate relationships while growing up. He often found his girlfriends to be clingy, and the relationships quickly became unhealthy and too

¹ The Oxford English Dictionary defines God as follows: “II. In uses relating to monotheism, and senses derived from this. (Now usually with initial capital.) . . . 5. Especially in Judaism, Christianity, and Islam: the Supreme Being, regarded as the creator and ruler of the universe.”

intense. Following high school, the patient entered college as a business major but left after two years to pursue truck driving. He also took on jobs in construction.

At age 33 he married his girlfriend from college. They had two children. During this marriage he was romantically involved with a past high school girlfriend, which eventually led to his divorcing his first wife and marrying the girlfriend. He had no further children and noted that his second marriage was complicated both by extramarital affairs and by his drinking, as described in more detail below. At the time of his first self-inflicted GSW, he had been separated from his (second) wife for the past year, though they were still legally married and lived in the same duplex home.

[2] Religious/Spiritual History

The patient described his upbringing as secular, with little attention given by his family or himself to religion or to the presence of a higher power. Around high school he came up with his own world view, with the belief that there was a scorekeeper watching when he did something wrong. He explained that he often acted selfishly, referencing his extramarital affairs, his road rage while working as a truck driver, and his occasionally submitting false timesheets at work. He stated that the scorekeeper noted all of these behaviors and sometimes punished him to keep him in line. The patient provided an example of being placed on a suspension at work after sending an insubordinate message to his boss. This action from the scorekeeper helped remind the patient to be on better behavior, but it did not indicate final or eternal judgment. The patient stated that he maintained this worldview throughout his adult life, with no contemplation of another higher power or other belief systems until he began to attend AA at age 53.

[2] Psychiatric History

Prior to his two self-inflicted GSWs, the patient had no history of self-harm or suicide attempts. He had been diagnosed with major depressive disorder in his late thirties due to symptoms of persistent low mood and low self-esteem, at times with accompanying social withdrawal and insomnia. He was treated with various selective serotonin reuptake inhibitors and serotonin-norepinephrine reuptake inhibitors, with sertraline showing the best effects. He was noted by family to have had occasional difficulty with anger and irritability, but prior to the weeks preceding his first self-inflicted GSW, he had had no manic or hypomanic symptoms. Prior to his second self-inflicted GSW, he had never been psychiatrically hospitalized.

In addition to major depressive disorder, the patient had struggled with alcohol use disorder. He described regular heavy drinking since his mid teens, which escalated in college and his adult years; at the height of his drinking, he consumed up to a pint of hard liquor and several beers each day. He denied having had withdrawal symptoms and had never been to detoxification treatment. He noted numerous problems in his relationships related to his alcohol use, with some of his partners disapproving of his use. Alcohol also played a role in his extramarital affairs, initial divorce, and problems in his second marriage. He reported developing increased tolerance over time. At age 53, he was charged with operating under the influence (OUI) for driving while intoxicated, which led to the loss of his job driving a truck. This loss was significant as he described truck driving as one of the only activities that he enjoyed and as a major part of his identity. His sobriety following the OUI charge prompted his first encounter with AA, as described below.

He denied a prominent history of other substance use, though he noted experimentation with cannabis use in his early twenties and a one-year period of experimenting with cocaine, several years prior to his self-inflicted GSW. He reported having no known family history of psychiatric illness.

[2] First Self-Inflicted Gunshot Wound

The patient described his first shooting not as an attempt to end his life but, instead, as a way to test whether God existed and cared for him. He explained that he had become sober from alcohol several months earlier. He had been motivated to achieve sobriety after losing his job as a truck driver. As with many patients attempting to achieve or maintain sobriety, the patient joined AA. In the context of attending AA meetings, he began to contemplate the existence of a higher power. He reports that, having been raised in a secular household, this was the first time in his life that he had seriously contemplated religion. He reported feeling hopeful when he learned from AA that there may be a higher power who could redeem his faults and past wrongdoings. He described guilt over his history of heavy drinking and also over the problems that his alcohol use had caused in his past relationships. These problems included various extramarital affairs in his two marriages and a sense that he had not been sufficiently present in the lives of his two adult children. Contemplating God gave the patient hope that these actions could be forgiven. He also feared, however, that he had done so much wrong in his life that even a benevolent God would not love him. He described his search for a higher power as being intertwined with his depression.

At the time of his spiritual questioning, the patient was seeing an outpatient psychiatrist for treatment of ongoing major depressive disorder. He had been stable on sertraline for several months at the time of his sobriety. His psychiatrist observed that the patient's depression seemed worse when the patient was no longer drinking. The patient reported he had not shared with his psychiatrist his spiritual questioning or his anxiety that no God could love him. He had shared, however, that he was anxious about being a bad person and that he had been having overwhelming guilt over his past wrongdoings. In this setting of apparent worsening mood, bupropion was added to his antidepressant regimen.

Less than one month after bupropion was initiated, while the patient continued to experience depressed mood, guilt, and low-self-esteem, he also developed new suicidal ideation, mood lability, increased energy, and increased goal-directed activity. He had never before experienced these or other manic symptoms. In the setting of his mixed depressive and manic symptoms, he continued to question God's existence and decided to test whether God cared for him. To carry out this test, he loaded a gun with a random selection from a pile of blanks and bullets. He planned to load the gun randomly and then fire it at his chin; if he fired a blank, he felt that this would indicate God's care for him. He later described this as "gambling with God." The first three times loading, he decided to check the gun rather than fire it. Each of those three times, he found he had loaded a blank. He then selected another object from his pile of blanks and bullets, and this time fired the gun below his chin. He states that after loading blanks the first three times, he felt sure he would not die the fourth time. The fourth time, however, he had loaded a bullet. After the gun fired, the patient was able to call 911 on his own, subsequently calling his wife to let her know what had happened.

The patient was brought to a hospital where he was treated for multiple facial fractures; the location of the lower facial injuries required intubation and ventilation. He sustained no acute intracranial injuries and did not need neurosurgical intervention. He underwent facial fracture repair and debridement, and external maxillomandibular fixation. The patient was seen by the hospital's consultation-liaison psychiatry team throughout his multiple-week hospitalization. He initially communicated by writing while intubated. Throughout his hospitalization he consistently reported he wanted to live, had not intended to end his life when firing the gun, and regretted having fired it. He reported he had been initially shocked that the gun had contained a bullet, as he had not thought that God would have let that happen. He later expressed regret over trying to test God in that way, and described such activities as arrogant, stupid, and immature.

Based on reports from the patient and his family, the consultation-liaison team determined that the patient had likely been in a mixed-mood episode at the time of the shooting, most likely with manic features prompted by his bupropion. The other diagnoses considered included a depressive episode with psychotic features, and cluster B traits and impulsivity. It was noted that a mixed episode in this patient would have been unusual, given the older age of onset of manic symptoms, lack of known family history of bipolar disorder, and bupropion's lower risk, compared to other antidepressants, of precipitating mania. Nevertheless, based on Mr. W's symptoms, a mixed-mood episode was deemed the most likely diagnosis. Bupropion was discontinued, and lithium was initiated. By the time of medical clearance, the patient was no longer in a mixed episode and denied a desire, plan, or intent to harm himself. He was discharged home with outpatient psychiatric follow-up.

Throughout the hospitalization, the patient was told by many that it was a miracle that he was still alive. The patient reported feeling that his survival was indeed a sign of a higher

power's existence. Though he had initially reported shock that God had allowed him to load and shoot a bullet, he later stated that God had let the gun go off in order to help the patient shift to thinking in a less selfish manner. He reported that God had allowed the gun to fire but had also allowed the patient to survive, noting that the latter was a sign of love and care.

[2] Second Self-Inflicted Gunshot Wound

Despite the patient's positive feelings about God during his first hospitalization, following discharge he soon began to experience increasing depressive symptoms, including low mood, hopelessness, insomnia, low energy, and decreased motivation to live. He reported feelings of guilt about the emotional and financial strain that his first self-inflicted GSW had placed on his wife and children. He became increasingly withdrawn from others; rarely seeing friends, he spent extensive time ruminating on his self-hatred. Though at the time of his hospital discharge he had wanted to live, as time passed he became increasingly dissatisfied with his life. Close to one year following his first self-inflicted GSW, he decided it would be best for his family if he ended his life. He reported that part of him had wanted to live for the sake of his children, but he ultimately thought he would be more useful to them if he was dead, which would ease them of emotional worry and provide them with money from his life insurance. He reported that he rarely thought about God or a higher power during this time, aside from at times thinking that his depression was so severe that no higher power would be able to help him. He remained sober but had not gone to AA since his first GSW.

He reported having considered suicide for several weeks prior to his second self-inflicted GSW, but he had planned the details of the shooting for only one day. He said he had considered

writing a goodbye note to family but decided not to, out of self-described laziness. He then shot himself in the chest, aiming for his heart. He reported suspecting aiming there was more likely to be lethal than shooting himself in the head, given that he had survived his first self-inflicted GSW. As his prior gun had been confiscated after his first self-inflicted GSW, he used an unregistered gun that he had previously hidden. His wife heard the shot and called 911.

The patient was medically hospitalized, where he had an emergent median sternotomy with exploration of the pericardium and right chest. He required repair of two major arteries but, given the location of the shot, overall had only minor anatomic damage. He stabilized quickly from a medical perspective. He was seen by consultation-liaison psychiatry and, once medically cleared, was transferred to inpatient psychiatry. On the psychiatry unit he was noted to initially go through a period of despair and rumination related to his self-inflicted GSW and the social consequences of this action. The consequences related mainly to his family; his wife placed a restraining order on him at this time due to fear that he might shoot her or others. As the hospitalization progressed he decided to pursue electroconvulsive therapy for ongoing severe depression. Over the course of several treatments (9 unilateral and 4 bilateral), he showed improvements in executive functioning, ability to break free from his ruminative thought processes, less social irritability, and greater capacity to engage in the group and milieu settings. Doxepin was initiated with good effect. Providers were initially wary of starting this medication, given its serotonergic properties and risk of precipitating mania. Ultimately they determined the risk to be acceptably low, given that his past manic symptoms had been prompted by bupropion's noradrenergic and dopaminergic effects. Since the patient's second self-inflicted GSW occurred in the setting of a depressive episode without mixed mood symptoms, providers also wondered whether his first GSW had occurred during a true mixed-mood episode and whether another

diagnosis may have better explained his symptoms. The presence of marked mood lability and increased energy at the time of the first GSW—but not the second—nevertheless suggested that he had indeed suffered from a mixed-mood episode. Mr. W's first GSW was also marked by a desire to test God rather than to end his life, and was followed by a rapid resolution of suicidal ideation and depressive symptoms. These differences between the two GSWs suggest that the patient suffered from two distinct psychiatric phenomena, despite their overlapping symptoms.

While on the inpatient psychiatric unit, the patient requested to speak with chaplaincy. In various therapy groups and conversations with chaplaincy, he made contrasting comments about his spirituality. At times he said that he had never had a spiritual experience. At other times he mentioned a desire to have a spiritual experience and wanting to know God better. He reported that God had saved his life in each of his two GSWs and that he planned to seek God further in the future. It appears that these statements fluctuated throughout his course in the hospital, without a clear linear trajectory in terms of belief in God or desire to know God.

At the time of discharge from the hospital, Mr. W expressed great appreciation for the hospital staff and expressed the hope to reconnect with family and to return to outpatient psychiatric care. He was referred to a partial hospitalization program to help him effect a transition back to the community, with referrals for outpatient psychiatry, AA, and community resources to help him return to work. Several months following his discharge he reported that he was continuing to struggle with depression, but he denied suicidality. He reported that he no longer attended AA meetings but had been sober for over two years (since his initial OUI charge). He reported being somewhat unsure about his spiritual beliefs but stated that he was beginning to believe a higher power existed, based on all he had experienced without dying. He

reported knowing that he would be unable to prove a higher power's existence, in contrast to his belief at the time of his first GSW. "I guess that's why they call it faith," he said.²

QUESTION TO THE CONSULTANTS

1. One could argue that the patient's focus on wanting to test God's care for him was the result of his mixed mood symptoms or that his mood symptoms were the result of his spiritual struggle. How can this be differentiated, and what are the implications for psychiatric formulation and treatment? (Dr. Pargament)
2. Prior to his first self-inflicted GSW, the patient saw a psychiatrist but did not spontaneously share his religious/spiritual questioning that eventually contributed to a near-lethal injury. How should providers elicit this type of information? (Dr. Griffith)
3. The patient describes his suicidality as being prompted by an existential crisis that arose due to his participation in AA. What should providers consider when referring patients to this or other treatments that may promote existential or spiritual reflection? (Dr. Peteet)

[2] Kenneth L. Pargament, PhD

The eminent pastoral psychologist Donald Capps once said that spirituality is elusive not because it is separated from human experience but because it is interwoven into human experience.¹ His comment applies well to the case of Mr. W, as reported above. Clearly, Mr. W is presenting with spiritual as well as emotional, social, and physical distress. Questions about whether there is a God, whether he is loved by God, and whether he can be forgiven for his transgressions, run like

² The case history was prepared by Larkin Elderon Kao, MD, and Sejal B. Shah, MD.

threads through the tapestry of his story. In addition to his many other concerns, Mr. W is struggling spiritually.

Spiritual struggles refer to tensions, conflicts, and strains about sacred matters within oneself, with others, and with the supernatural.² Six subtypes of spiritual struggles have been empirically identified: moral struggles; doubt-related struggles about the truth of religious claims; struggles of ultimate meaning; struggles with other people about sacred issues; struggles with God; and struggles about evil or demonic forces.³ These subtypes may not reflect the full range of spiritual struggles, but they do cover a variety of spiritual strains and conflicts relevant to people holding divergent views and attitudes on religion and spirituality, including those of atheists.⁴ It is important to add that although spiritual struggles can be understood, in part, as religious and spiritual problems (*Diagnostic and Statistical Manual of Mental Disorders* [DSM]-5 Code V62.89),⁵ they should not be reduced to psychiatric disorders; spiritual struggles can also be sources of positive transformation and mental health.⁶

What role do spiritual struggles serve in psychiatric problems, such as those presented by Mr. W? Empirical research has demonstrated robust links between spiritual struggles and a variety of indicators of psychopathology.^{7,8} Much of this research leaves unanswered, however, the question of whether spiritual struggles are a source of psychopathology or the end result of serious psychological problems. This question has important implications for the treatment of cases such as that of Mr. W.

Pargament and Lomax⁹ described three possible causal connections between spiritual struggles and psychopathology. *Primary spiritual struggles* play a direct role in producing psychological problems. For example, Martinez-Taboas¹⁰ recently published a case study of a young, very religious woman who was experiencing psychogenic non-epileptic seizures in both

legs. The seizures appeared to be generated by a spiritual struggle related to whether she wanted to commit herself to a life as a nun in a convent. Because the somatoform disorder was seen as a by-product of her primary spiritual struggle, the therapist focused on helping her address her spiritual conflicts within herself, her family, and her church. The treatment was successful in eliminating the seizures. Empirical studies have also shown support for a primary spiritual struggles model. For example, in one study, medically ill elderly hospitalized patients with higher levels of spiritual struggles were at greater risk of depression, loss of functional status, and mortality over the following two years.¹¹

Secondary spiritual struggles are triggered by underlying psychiatric problems. For patients experiencing secondary spiritual struggles, focusing on the core psychological disorder may resolve not only the psychiatric symptomatology but also the spiritual struggles. Griffith and Griffith¹² present the illustrative case of a woman with bipolar disorder who had been hospitalized to remove a brain tumor. There she suffered an injury to her eye that required surgery. The patient refused surgery, however, and began clawing at her eye, quoting from the Bible: “If your eye offends you, pluck it out.”^{12(p 244)} Judging that her religious zeal was rooted in a psychotic disorder, her psychiatrist treated the patient with antipsychotic medication. That treatment was successful in reducing both the patient’s delusions and spiritual struggles. The patient later apologized to her psychiatrist “for making your life hell.”^{12(p 245)}

Complex spiritual struggles are both a cause and effect of psychological problems. This form of struggle may best describe the experience of Mr. W. In one sense, his spiritual struggles appeared to trigger more severe psychological problems. Prior to his first self-inflicted GSW, Mr. W had been experiencing moral struggles tied to his heavy drinking, job loss, and extramarital affairs. He also described a related set of divine struggles about whether he could be forgiven for

his misdeeds and loved by God. These struggles exacerbated Mr. W's depression.

After starting bupropion, however, Mr. W began to manifest manic as well as depressive symptoms. These mixed symptoms intensified Mr. W's spiritual struggles and prompted his "gambling with God" game of Russian roulette to resolve the question of whether he was actually loved by God. Complex spiritual struggles such as these call for a multimodal, spiritually integrated approach to treatment,¹³ defined as one that includes spirituality in the process of fostering insight and mental health.

Unfortunately, spiritual issues often go unattended in mental health treatment. Patients themselves may be reluctant to broach these topics. Following his first GSW, Mr. W admitted that he had not shared with his outpatient psychiatrist his spiritual questioning or his anxiety that no God could love him. A spiritually integrated approach might include questions during the intake interview that could potentially open the door to conversation about struggles and other relevant spiritual matters. Consider these illustrative probes: "Have you been experiencing tensions, conflicts, questions, or struggles about religion or spirituality?" and "How have your problems affected you spiritually?"

Attending to spiritual concerns could have also been useful at the time of his discharge following his second GSW. Mr. W was no longer suicidal, but he continued to present with signs of spiritual uncertainty and confusion. Given the significant role of spiritual struggles in his life, a spiritually integrated treatment would seem warranted to address Mr. W's spiritual concerns. An insight-oriented approach could help Mr. W explore the potential roots of his struggles, such as his sense of isolation and loneliness as a child, feelings of insecure attachment to God (perhaps mirroring his insecure attachment to his parents), and childlike conception of a "scorekeeper God." Therapy could also help Mr. W consider and move toward a more mature

spirituality and understanding of God, one which would allow him to take more responsibility and control over his own life. Spiritually oriented rituals, readings, and practices, such as mindfulness, could be particularly valuable in short-circuiting Mr. W's ruminative and risky spiritual struggles about whether he is ultimately worthy of being loved by God. Of course, practitioners must be careful to avoid taking on the role of theologians or clergy, and, instead, work within the boundaries of their professional competence. But given this patient's complex spiritual struggles, a spiritually integrated approach—one sensitive to both the spiritual dimension of psychiatric problems and the potentially valuable role that spiritual resources can play in therapy—would likely prove helpful in treating Mr. W.

[2] James L. Griffith, MD

Cultural factors can contribute to a patient's hesitancy to reveal his or her spiritual life to a psychiatrist. Though various authors and practitioners have embraced the overlap between mental health and spirituality, historically spirituality and religion have more often been stigmatized within psychiatry, in part due to the popularization of Freudian psychoanalytic thought in the mid twentieth century.¹⁴ Though the matter has not been formally studied, one would expect that patients aware of this stigmatization may expect a psychiatrist to dismiss or ridicule their spirituality. In addition, life-changing religious experiences can be difficult to put into words. Powerful religious experiences can exist inchoate and viscerally felt, but beyond language. As philosopher Martin Buber observed, a relationship with the Divine “does not use speech, yet begets it. We perceive no Thou, but none the less we feel we are addressed and we answer— forming, thinking, acting.”^{15(p 6)} For each of these reasons, clinical skills are needed to

listen for that which has not yet been expressed. An active invitation from the clinician is needed that conveys respect and authentic interest.^{12,16}

Existential questions are useful tools for learning about a patient's spiritual resources. They strike a balance between inviting discussion of spirituality and respecting a patient's preference not to speak when such inquiry would feel off-putting due to negative past associations with religion. Existential questions can be introduced seamlessly into most initial diagnostic interviews. Across cultures and different spiritual traditions, spirituality and religious practices strengthen resilience against adversity. Religion and spirituality help people to bear suffering and to uphold important identities, values, and relationships. Existential questions inquire how a person responds to the struggles and sorrows of daily life. Existential questions usually are felt to be normalizing, rather than pathologizing, since they ask about similar dark places through which all people, including the clinician, eventually walk. Their aim is to open a conversation about "what matters most" in the patient's life—which allows a natural progression into discussion of struggles involving religion or spirituality.^{12,16,17}

Mr. W initially presented to a psychiatrist for low mood and low self-esteem, accompanied by social withdrawal and insomnia. In his initial interview, his psychiatrist might have said, "I've asked you a number of questions about symptoms, but I also need to get to know you as a person . . ." Following this transition, different existential questions might have been posed, including the following:

- Is this depression the hardest thing you have faced in your life, or have you faced worse?
During such hard times, what has sustained you? What kept your hope alive that life could be worth living?

- What is your best sense of what your life is about? If you were fully thriving as a person, what would be happening in your life that is not happening now?
- What most gives your life a sense of worthiness?
- For whom, or for what, does it matter that you live and persevere?
- In troubled times, where do you find peace? When you are afraid or in pain, how do you find comfort?
- Who truly understands your life? Who is worthy of your trust?
- For what are you deeply grateful?
- What most stands in the way of your becoming the person you most want to become?

In their breadth, these questions can be considered as a “review of systems” for the different ways in which spirituality and religion can help strengthen a person in the face of adversity. They open serious conversations that enable the listening clinician to discern which themes are paramount in importance for a patient’s life. Although the words *spirituality*, *religion*, and *faith* are not used explicitly in these questions, it is common that a patient who has an active spiritual life will begin discussing these matters when these questions are posed. More specific questions then can be asked, using language appropriate to the patient’s worldview.

For Mr. W, one or more of the above questions might have revealed that he did not adhere to a particular religion or set of theological beliefs. He did believe, however, that a moral accounting was kept of each person’s deeds (the “scorekeeper”) and that his life felt unworthy. This information potentially could have opened an additional therapeutic avenue for utilizing his spiritual sensibilities, in addition to treating his depressive symptoms with medications and an

evidence-based psychotherapy. Examples of questions that could further expand this avenue might include the following:

- Your image of the scorekeeper conveys a strong moral sense of right and wrong. What were some important life experiences that contributed to the development of this strong moral sense in your life?
- If you were to think of this sense of right and wrong as giving direction to your growth as a person, where would that growth be headed over time? What might your life look like if it were to reach fruition? Would that be a kind of person you desire to become?
- What would indicate to you that you were achieving worthiness?
- Do you suppose the scorekeeper would be aware of, and feel compassion for, you as you faced the difficulties and struggles of your life?

Learning about a patient's spiritual resources in an initial diagnostic interview is challenging on multiple fronts. Due to the legacy of stigma by mental health professionals against religion, an active invitation is necessary that makes clear to patients that discussion of spirituality is relevant and welcomed. Unfortunately, the descriptive psychiatry of DSM-5 diagnostic interviewing is a discourse with minimal space for problems of persons, rather than symptoms of disorders. Existential questions are a useful tool for learning about a patient's spiritual resources through an inquiry about the person's response to adversities of life. Strengthening of the patient as a person adds a new therapeutic avenue that complements treating symptoms into remission.

[2] John R. Peteet, MD

Mr. W reports a lifelong conception of God as a scorekeeper who played a necessary role in his life. While attending AA meetings, he began to envision a higher power who could potentially “redeem his faults and past wrongdoings.” Doubts about whether he could be forgiven seem to have driven, at least in part, his dangerous gamble to prove God’s existence. It is notable that he retained his sobriety even though he did not continue the program of AA after either GSW and did not appear to engage with a faith community.

Patients commonly report that attending a 12-step program enhances their spirituality.^{18,19} This is perhaps an unsurprising observation since these programs describe themselves as “spiritual but not religious” approaches to achieving sobriety and effective living. But how does the spirituality of AA engage the needs of an individual struggling with addiction? Elsewhere²⁰ it is suggested that AA addresses existential concerns in the areas of identity, integrity, an inner life, and interdependence, in both positive and potentially negative ways. For example, it is a strongly expressed conviction of some members that the program is the only possible path to recovery, similar to the manner in which one might view his own spiritual or religious beliefs as the only path to salvation. While such an approach could be helpful for some patients, others may perceive it as rigid and exclusive, potentially leading them away from an otherwise helpful treatment option or precipitating a sense of shame or rejection.

Mr. W appears to have been primarily concerned with his moral failings or lack of integrity. Several of the 12 steps stress the need to acknowledge moral failure, begin restitution, repair defects of character, and be of service to others. Many individuals find steps 4 and 5

especially challenging; they instruct individuals to take a “fearless moral inventory” and then relate it to another person.²¹

We are not told if Mr. W took these steps or experienced more than the hope of potential forgiveness by God. We also do not know what influence his AA meetings had on his conception of God. Some meetings include religious prayer implying a personal God, whereas others encourage members to think of their higher power in any way they want—for example, “as a tree, or the group.” Though the higher power is supernatural for some, it need not be for all participants.

Could it have been helpful for Mr. W to look for answers to his sense of moral failure in a faith community? All major faiths offer a pathway to forgiveness, but Mr. W’s background was secular, making it more challenging to help identify a resource of this kind for him.

Mr. W’s distressing spiritual struggle is an example of the DSM-5 Code V62.89, Religious or Spiritual Problem.⁵ As a distressing condition for the patient, this type of problem can be an appropriate focus of clinical attention. But what is the role of a clinician in helping such an individual find answers, peace, or forgiveness? Arguably, the first step is to understand the patient’s problem, including both its emotional and existential/moral/spiritual dimensions. Mr. W appears to have been moved by a realistic sense of guilt for having failed others but also by a conviction of being unforgivable, which was symptomatic of the depression that eventually required electroconvulsive therapy.

A second step is for a clinician to help the patient identify resources for dealing with his existential/moral/spiritual struggle consistent with his own tradition or worldview. These resources might include apology, confession, making amends, or asking forgiveness from God.²² Such interventions could be pursued in the setting of psychotherapy or through utilizing

community resources such as faith-based communities, 12-step programs, or close family or friends.

This leads to a third step, which is to address the obstacles experienced by the patient in making use of these resources. Is access to them being impeded by a history of hypocrisy or abuse by religious figures, by disappointment by authority figures in the patient's early life, or by an intractable depression? Is the patient's current theology or religious authority emphasizing judgment over mercy? In the case of Mr. W, what was the nature of his particular AA group or sponsor? Cook and colleagues,²³ among others, have pointed out the potential for rigid or conservative AA members to discount an individual's need for therapy or medication. This problem is also characteristic of some rigid or conservative faith communities, which highlights the importance for clinicians to have a basic knowledge of the range of spiritual approaches to experiencing forgiveness. For hospitalized patients, chaplains can often help patients find appropriate community or clergy resources available within their spiritual traditions.

A fourth step is to help the patient to act to address both the emotional and the existential/moral/spiritual aspects of the problem, including through medication, therapy, or spiritual practices. Spiritually integrated therapy is defined as therapy that takes into account the role of spirituality in patients' lives. A recent meta-analysis of spiritually integrated therapy showed that it was better accepted by some patients than, and at least as effective as, alternative secular therapy.²⁴ The relevance of communal spiritual practices for mental health was recently underlined by an analysis of data from the Nurses' Health Study.²⁵ Among 89,708 women who participated, attendance at religious services once per week or more was associated with an approximately five-fold lower rate of suicide compared to those never attending religious services.

Mr. W's high-stakes struggle with guilt over his moral failures bears some resemblance to the moral injury experienced by returning veterans who have witnessed or participated in events that transgress their deeply held moral beliefs and expectations. Emerging treatments for moral injury have included clarifying the meaning of the events, engaging in an imagined dialogue with the victim, finding group support, achieving self-forgiveness, and making amends.^{26,27} Since many of the preexisting moral standards and values that are transgressed stem from religious beliefs and faith practices, religion and spirituality are often critical components of treatment.²⁸

In summary, self-help and faith-based groups that deal with existential and spiritual issues, such as AA, can offer community, context, and coping resources for individuals struggling with religious or spiritual problems such as the guilt plaguing Mr. W. These groups can also reinforce, however, ways of thinking that are unhelpful—for example, by being overly moralistic. When patients are alienated from potentially helpful resources, clinicians can explore and address the intertwined existential and psychiatric issues involved, refer when appropriate, and help individuals engage in constructive practices through spiritually integrated therapy.

Declaration of interest: Dr. Kao's spouse is employed by Alkermes.

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