Religion and Spirituality among Older Adults in Light of DSM-5

James W. Ellor

With the introduction of DSM-5 the age-old debate as to the role of religion and spirituality in mental health is once again engaged. Like DSM IV, DSM-5 continues to offer V Code, 62.89, Religious or Spiritual Problem. However, it also offers an expanded understanding of culture and the impact of culture in diagnosis. As a part of the author's discussion, DSM-5 includes spirituality as a critical factor in culture. This article explores some of the history of the debate on religion and spirituality in the mental health and gerontology literature, asking if the delegation of religion and spirituality to culture is adequate to understand the fullness of the historic debate over their role in counseling practice with older adults.

Mrs. Coryell is a 71-year-old grandmother who presents to you for counseling with a deep concern for her granddaughter who has just been checked into psychiatric care at a local hospital. Her granddaughter has been diagnosed with postpartum depression. Her granddaughter told her husband that the devil was telling her to kill her newborn child in order to heal her relationship with God. The granddaughter was conflicted about this and after talking with her physician and her pastor, checked herself into psychiatric care…without hurting her child. Mrs. Coryell is very anxious about this. She is glad that her great grandchild is all right, but feels that no one is paying attention to the battle between God and the Devil, which is clearly going on, and equally certain that her granddaughter will not get better until this is addressed.

The first obligation of any social worker is to listen to the client. As much as we try not to allow our biases to get in the way of how we listen to the client, our training puts us in the position to think about Mrs. Coryell in one of two ways.

Social Work & Christianity, Vol. 40, No. 4 (2013), 372–383
Journal of the North American Association of Christians in Social Work

First, one can identify the daughter as has having postpartum depression and her grandmother as having some type of anxiety disorder. This psychiatric diagnosis would be recognized by the interdisciplinary team at the psychiatric facility. If the psychiatric facility is aware of grandmother's anxiety, they might connect the grandmother and granddaughter and find a family system or even an environmental concern or a V Code from DSM-5 that would offer some context for these two diagnoses. A second approach would still understand the psychiatric disorders noted above, but would seek to fully understand the religious or spiritual elements found in this family and environment.

While the first approach has precedent within the various social work systems, there is expanding support for incorporating the second approach into our ability to listen to this client. The dialogue between religion, spirituality and counseling practice has been going on for over one hundred years. In many ways, the new *Diagnostic and Statistical Manumal-5 (DSM-5)* moves this discussion forward by clarifying the role of spirituality as being a part of cultural assessment. While this is where CSWE and most of the other professional counseling organizations have already focused this dialogue, it is new to the DSM series. In this article I will attempt to sort out some of the elements of this historic debate and begin to discuss a diagnosis and treatment based on DSM-5 that can help guide the practitioner to work with clients like Mrs. Coryell.

A Short History of the DSM Series and the Role of Religion and Spirituality

The concept of assigning a name to an emotional disorder can be traced back to the ancient Greek physicians. However, diagnosis in psychiatry as it is known today is relatively recent. Individual diagnoses such as "delirious mania," later renamed "malignant catatonia," was contributed to the profession in 1849 by Luther V. Bell, chief physician at the McLean Asylum for the insane in the Boston, Massachusetts area (Shorter, 2013, p. 4). The first modern list of psychiatric diagnoses is credited to William Menninger, who in 1945 was in charge of psychiatric services for the U. S. Army during World War II. Menninger developed a diagnostic list referred to as Technical Medical Bulletin no. 203 (Medical 203 for short) (Shorter, 2013, p. 5.) The Diagnostic and Statistical Manual (DSM) series was initiated in 1952 with DSM-I.

While the DSM series has always reflected a diversity of perspectives or paradigms, there have often been key figures who have dominated at least certain areas of the system. For example DSM-I was grounded in the work of Adolf Meyer (Meyer & Lief, 1948). Meyer brought in such concepts of "reactions" rather than the use of the term disorders, as well as a press for the new book to be more about connecting diagnosis to treatment than is

found today (See Meyer & Lief, 1948 p. 142). DSM II "featured psychoanalysis on the bowsprit" (Shorter, 2013, p. 7). The Freudian influence could be felt in the psychoanalytic emphasis of the original diagnoses found in DSM II. It can also be observed that in the area of personality diagnoses, DSM III and DSM IV were dominated by the writings of Theodore Millon as six of the 11 personality categories reflect Millon's eight categories. It has also been said by many that particularly DSM IV was influenced by the drug industry as many of the diagnoses seem to match the descriptions for the use of certain drugs. These types of influence, while in line with the state of the art in mental health diagnosis and treatment, were not always consistent with the best evidence-based practice.

The purpose of the DSM series has also evolved over the years. The Medical 203 system of 1945 established at least one of the important goals, to develop greater uniformity of diagnosis. Soldiers within the military system and other client groups often move from one medical system to the next, thus creating the need for consistency. The second goal of the series was to facilitate treatment. DSM-5 opens with the statement, "Reliable diagnoses are essential for guiding treatment recommendations" (DSM-5, 2013, p. 5). Three other goals for the new DSM-5 have also been added.

First, there is a goal for this approach to be evidence-based. The challenge to the concept of evidence-based practice is always in the quality of evidence the approach is using. This is where the various teams of scholars and practitioners have come in to sort out these concerns.

A second goal, which was also true for DSM-II, was to harmonize DSM-5 with the International Classification of Disease (ICD) codes from the World Health Organization, currently on ICD-11. These codes reflect the categorization of diseases by the World Health Organization and are used by medical doctors, but also influence psychiatry.

In DSM-5, a third goal reflects a dimensional approach to diagnosis. "Because the previous DSM Approach considered each diagnosis as categorically separate from health and from other diagnoses, it did not capture the widespread sharing of symptoms and risk factors across many disorders that is apparent in studies of comorbidity (DSM-5, 2013, p. 12). In DSM-5, the various disorders are clustered according to internalizing and externalizing factors (DSM-5, 2013, p. 13).

Finally, DSM-5 seeks to enhance Development and Lifespan considerations to place the various diagnoses in the context of life markers and socio-cultural conditions (DSM-5, 2013, p. 13).

With these changes has come a larger discussion of spirituality as a part of culture. In the DSM-IV series, Religion or Spiritual Problems were incorporated as V Codes. V or, starting in ICD 10, Z Codes were established by the authors of ICD 9. They are not conditions, problems, or mental disorders. They reflect additional issues that may be useful to clinicians in documenting the underlying pathology (DSM-5, 2013, p. 715). V Codes

have continued to be used in DSM-5, including V62.89 (Z65.8) Religious or Spiritual Problem. It should be noted that V62.89 is virtually unchanged from DSM IV TR. It notes, "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" (DSM-5, 2013, p. 725).

While the addition of V and Z codes continues the tradition of understanding religion, not as pathology, but as something that impacts or colors a pathology, DSM-5 goes on to offer a significant discussion of "Cultural Formulation" (DSM-5, 2013, p. 749). This section explores the various aspects of culture that impact clients. In this section, "culture includes language, ***religion and spirituality***, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems" (DSM-5, 2013, p. 749, emphasis mine). By placing religion and spirituality squarely in the category of culture, the authors of DSM-5 have established their solution to the age-old debate as to the role of religion and spirituality in psychiatry.

The debate over the role of religion/spirituality in counseling has been carried on in ways that it has not been reflected in such fields as nursing or medicine in general. Since at least the 1960s, counselors have felt that religion and subsequently, spiritualty, did not belong in counseling for several reasons. First, persons in the counseling professions throughout the 1960s, 70s and 80s were significantly less likely to perceive themselves to be religious (Cook, 2013, p. 7). Within Social Work, the North American Christians in Social Work organization has often been an island of faith within a boiling caldron of humanists who ranged from feeling religion to be irrelevant to those who found it offensive. C.H. Cook (2013) adds five other reasons including:

2. It is considered unimportant.
3. It is considered important, but irrelevant to psychiatry.
4. We feel we know too little about it ourselves to comment, or even to ask questions.
5. The very terminology is confusing and hence embarrassing; it is not respectable.
6. There may also be an element of denial in which it is easier to ignore this area than to explore it (p. 5)

Many of these rationales for the separation of religion from psychiatry related to barriers of knowledge. In some cases the lack of knowledge about religion may have reflected a lack of personal interest in it. For others there is a clear division of labor suggesting that clergy should deal with religion and psychiatry should address emotions.

For gerontologists there is still another concern that reflects the fear that if the therapist is open to discussion about religion or spirituality, she

or he will be crossing the church and state boundary. The separation of church and state dialogue was raised as far back as the writing of Thomas Jefferson and was brought up once again in the Presidential Debates between President Richard Nixon and his challenger Hubert H. Humphrey in 1968. With many social workers employed by public agencies, this line was affirmed and often impregnable, even when a client initiated a religious or spiritual topic. Cook (2013) documents that this began to change for social work in the 1990s (p. 3) in both training and the literature. It changed somewhat earlier in gerontology (See Ellor & McGregor, 2011) as by the mid 1980s the numbers of articles and journals dedicated to this topic greatly increased. However, the development of a single cogent vision as to how to understand or use religion and spirituality has yet to be developed. Traditionally in Social Work as well as in the other counseling professions, religion and spirituality have been relegated to the area of cultural concerns. In DSM-5 this is perspective is affirmed.

Most thoughtful theologians and sociologists would agree that religion and spirituality do impact culture (Malefijt, 1968). Depending on which author one reads there is some debate as to whether religion impacts culture or if culture impacts religion. However, clearly there is a connection as demonstrated in DSM-5. DSM-5 notes connections in areas of language, ethnic perception, cultural identity, and the use of religion and spirituality in times of stress. It further notes that religion and spirituality can be barriers to treatment, much as it was for Mrs. Coryell and her daughter, and it can alter help seeking patterns when the client seeks guidance from a Minister, Priest, Rabbi or Imam rather than a mental health professional. The question for the thoughtful Christian social worker is whether limiting the role of religion and spirituality to its impact on culture adequately expresses the depth of the impact that they have on the client?

Understanding the Terms

Wholism

Wrestling with the question of the role of religion and spirituality in mental health starts with a discussion of the relevant terms. Within the discipline of philosophy, defining terms is generally the starting point in any argument (Blackburn, 1999). DSM-5 employs the terms religion and spirituality. While it would be logical to start with a definition of religion and spirituality, it may be more useful to start with the concept of Wholism as most practitioners who think wholistically about their clients start there. Viktor Frankl starts this discussion with the term "holism" in his critique of religion and psychotherapy. Frankl states, "True human wholeness must include the spiritual as an essential element" (1961 p. 2). In this context, Frankl, a former student of Alfred Adler's, is actually criticizing his former

mentor as well as the field of psychiatry, since Adler's formulary for holism includes only the physical, social, and emotional aspects of the person. By developing his concept of holism, Adler is in turn critiquing Sigmund Freud, who, as a surgeon, sought to pull apart the nature of the person for study as well as in therapy. The Adlerian argument suggests that to amputate a leg is not just a physical assault on the body, but an emotional assault as well; the two cannot be separated. Viktor Frankl in 1961 advocated for not three, but four aspects of the whole person to be included in understanding the nature of the person—physical, social, emotional, and spiritual.

In the 1970s, a Lutheran Chaplain by the name of Granger Westberg talked about this fourth dimension while lecturing to medical students. Westberg acknowledged that the three aspects of the person identified by Alfred Adler were the current state of the art, yet to fully understand the person we need to see the spiritual as the 4th dimension. Larry Renetsky writing in 1977 in *Paraclete*, the forerunner of *Social Work & Christianity,* also referred to the spiritual as the 4th dimension. During Westberg's discussion with the medical students they asked if there was not some way of distinguishing holism which has only the traditional Adlerian three aspects from the understanding of the whole person that has four. Drawing on the work of an earlier pastoral theologian, Westberg suggested they spell it Wholism with a "W". Granger Westberg is best known today as the founder of Parish Nursing.

The challenge for the wholistic practitioner who accepts the 4th dimension (Renetsky, 1977) starts out with understanding each dimension and then becomes more complicated by the need to understand how the various dimensions interact with one another. Frankl suggests, "moreover, the spiritual is precisely that constituent which is primarily responsible for the unity of man" (Frankl, 1961, p. 2). There is not one clear way of understanding the interaction of the various dimensions of the person, but it is clear that the intention of Adler, Frankl, Renetsky, and Westberg is to understand that one cannot tear any of these four apart. This has led numerous authors to suggest that it is artificial to even think of the whole person in dimensions, since particularly the religious or spiritual dimensions are fully integrated into the physical, social and emotional aspects of the person.

Religion

Historically, the term "religion" has been the first to enter the dialogue. Psychiatrists like William James and numerous sociologists like Durkheim or Weber all employed the concept of religion as a critical part of their analysis of the human condition. The definitions of religion have changed over the years. Depending on the author, religion can refer to denominations and churches, synagogues, temples, and mosques. They can also more informally reflect congregations, dogmas, and faith traditions.

One useful definition by Koenig, McCullough, and Larson, (2001) states "Religion is an organized system of beliefs, practices, rituals, and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality) and (b) to foster an understanding of one's relationship and responsibility to others in living together in a community" (p. 18). However, in a schematic on the next page of their text, these authors identify religion with the various religious traditions. In many ways this definition incorporates both types of definitions of religion.

In a literature survey by Ellor and McGregor (2011), it was clear that the term "religion" is generally used to reflect the various corporate aspects of religion by one definition or another. The term religion found its way into research as the term religiosity with a similar definition. A religiosity scale generally included elements of religion and always included questions about Church attendance and frequency of prayer. These two questions continue to offer the greatest value for correlation with other variables in many studies.

Spiritual Well-Being

In the late 1960s a second term began to be explored by in the field of Gerontology, Spiritual Well-Being (Ellor, J. and Kimble, M., 2004). The term Spiritual Well-Being (S W-B) was developed as the direct result of the Nixon election to the White House. The tradition in legislation to benefit older adults was that every ten years there would be a White House Conference on Aging. Various White House Conferences were developed in the 1950s to the 1980s. The purpose was to offer a forum for constituents and advocates for constituents to come together with congress to talk about legislative needs. In 1951, White House conference was held with sections of a variety of topics, including transportation, housing, recreating, and religion. The religion papers for discussion for this conference were written by Paul Maves. Again in 1961, a White House Conference on Aging was held with papers again written by Paul Maves.

In 1970 as the result of the Nixon-Humphrey debates on the separation of Church and State, the staff that was designated to develop this new conference was told that there could not be a section on religion in a publicly funded conference. Drs. Kimble and Ellor (1996) interviewed Arthur Flemming, the director of the 1971 White House Conference on Aging. According to Flemming, Clark Tibbits, one of the key planners of this conference and other planners continue to want the religious section represented, so they decided that they needed a new term. Clark Tibbits, through his work as a gerontologist, had participated in the development of a concept known as Psychological Well-Being, also referred to among gerontologist as "Happiness scales." Psychological well-being scales are used to understand the respondent's sense of satisfaction or happiness with

some aspect of emotional health. Tibbits suggested that if there could be something like psychological well-being, maybe there could be something called spiritual well-being (Ellor & Kimble, 2004).

In order to field test his concept, Tibbits called a friend in Indiana, Grover Hartman, who was in the process of developing a workshop and asked him to field test it. The workshop was subsequently called a spiritual well-being conference. Hartman got back to Tibbits, suggesting that it seemed like a good term. It was then used by the 1971 White House Conference on Aging. Thus, there was a section on Housing, Transportation, Health, and Spiritual Well-Being. The papers for this conference were written by David O. Moberg. While Moberg's papers were helpful in organizing the religious community and creating the National Interfaith Coalition on Aging, currently a part of the Forum on Religion, Spirituality and Aging, a constituent unit of the American Society on Aging, Dr. Moberg never defined the term (Ellor & Kimble, 2004).

In 1975, the founders of the National Interfaith Coalition on Aging (NICA) were developing their Inter-Decade conference on Spiritual Well-Being and recognized that they needed to define this new term. Meeting at a Holiday in near O'Hare Airport in Chicago, 33 representatives of a wide variety of religious traditions met and come up with the following definition: "The affirmation of life in a relationship with God, self, community and environment that nurture and celebrates wholeness" (National Interfaith Coalition on Aging, 1980 p. xiii). The term "spiritual well-being" became an alternative, politically correct option along with religion in the gerontology literature. The challenge in the use of this term reflected the problems involved in trying to operationalize it for research purposes. Not unlike the terms "religion" and even "spirituality," at times it seemed to be defined as an alternative to religion and at other times it sounded more like the current use of the term spirituality. Only a few understood the history of the term and employed a spiritual happiness definition.

Spirituality

By the late 1980s the term "spirituality" had gained prominence in the gerontology literature (Ellor & McGregor, 2011). The term religion was and is still in use, but the term spirituality has been seen as more useful, both as a more personally defined aspect of the person and in research. The concept of spirituality is actually a very old term, used for thousands of years by the mystics within the Christian, Jewish, and Islamic communities. For many traditional Protestants, it was a relatively new term in the 1980s. It is not a part of the teachings of the reforms such as John Calvin, Martin Luther, or John Wesley.

Coming from the mystical tradition, the concept of spirituality is often confused with the concept of the spirit, such as the Holy Spirit, or Spirit

of God. Spirituality in many mystical traditions can be understood as the human spirit, or as that aspect of the person that reaches out to the divine. Koenig, McCullough and Larson (2001) offer the following definition, "Spirituality is the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community" (p. 18). The concept of a personal quest for understanding allows both therapists and researcher to avoid the separation of church and state issues of the 1970s and points back to Viktor Frankl's suggestion that without the spiritual, it is challenging for a therapist to work with clients to understand the meaning in their lives (Frankl, 1961, p. 2). In Frankl's Logo Therapy, the path to meaning in life runs through transcendence. In psychology, this is referred to as self-transcendence; in religion it is referred to as divine transcendence; but as Frankl notes, both terms employ the same word "Geist." The principle distinction is in the suffix applied to the root word, spirit (Ellor, 2005).

The arguments for the adequacy of placing spirituality in a section on culture are firmly grounded in an understanding of the human spirit that suggests that the spirit is that aspect of the human being that reaches out or transcends to other persons and is a critical step on the road to meaning. Human culture clearly integrates the whole person and is distinctive to humanity compared to other species.

The question remains, it is adequate to fully address the questions of the client, or even Mrs. Coryell, from our case at the beginning of this article? Are there other ways to understand spiritual assessment that might be more productive for understanding the needs of the client? These questions seem to depend on whether the social worker is prepared to understand that the divine or God is involved in the understanding of the person. Most religions argue that God created the world as we know it. But, the question rests in terms of whether God continues to be a part of creation.

Role of View of God

Froese and Bader provided the analysis of a section of the Baylor University Survey of American Religion: Longitudinal Survey of Religious Beliefs and Values that took place between 2005 and 2007. This was a national sample conducted by the Gallup organization to understand religious beliefs in America. With a carefully selected sample of more than 3,000, this survey was a diverse cross section of persons in the United States.

Froese and Bader examined those questions that related to how respondents view God. After analyzing the data around dozens of questions, they found two that had significant correlation; "To what extent does God interact with the world? And, "To what extend does God judge the world"

(Froese and Bader, 2010. p. 10)? Their findings revealed that the images that Americans have of God vary considerably. In order to better understand these images, they created a method for categorizing them. They placed the images into one of four groups; Benevolent, Authoritative, Distant and Critical. They found that the four groups could be explained by how engaged in the world the respondents saw God to be and the extent to which they saw God to be judgmental.

The first image and most common was the authoritative God. The **Authoritative God** is actively engaged in the world and continuously judgmental in the people's lives. Approximately 31% of the sample fell into this group. The second is the **Benevolent "God**, who is engaged, yet nonjudgemental" (Froese & Bader, 2010 p. 26). Approximately 24% of the sample fell into this group. The third image of God is that of the **Critical God** who is not engaged in the world, but reserves judgment for the afterlife. Approximately 16% of the sample fell into this group. Finally, there is the **Distant God**, who is both nonjudgmental and not engaged (Froese & Bader, 2010, p. 26). Approximately 24% fell into this group. In this study 5% fell into a category of persons who do not believe in any understanding of a God. Ellor and Stanford are currently working to correlate these images of God with mental health variables such as depression and anxiety, locust of control and capacity for relationships.

For this discussion, the interesting part of this concept is the role of the image of a God who is active in the world. Mrs. Coryell clearly believes in a God who is active in this world. If one asks Mrs. Coryell, she would most likely also say that she believes in miracles. The Baylor study carefully surveyed persons from all of the world's religious traditions and Froese and Bader found that this categorization worked across all of these traditions. In some way their concept is misnamed, since in a way, the image of a non-God is still an image of God; it is just of a God that does not exist. From this perspective there are five God images, 55% of the respondents who hold one of these images believe in a God image that continues to be active in the world. This includes for Benevolent God believers a God who does not create disasters but is there to walk with us when we are down and for Authoritative God image persons a God that will judge and send judgment upon individuals in this life.

For Mrs. Coryell and for this group who reflect 55% of this sample, reducing her granddaughter's conflicts to Post-Partum Depression fails to reflect her understanding that God can be and is active in this world and that maybe this is not a challenge in her granddaughter's emotions alone. Maybe it is a part of a larger cosmic struggle between God and the devil.

Does Culture Restrict Religion/Spirituality in Social Work Practice?

An examination of the state of religion and spirituality in DSM-5 suggests that in some ways there is significantly more support for an understanding that religion and spirituality play an important role in the life of the person. Much like the classic study, the *Three Christs of Ypsilanti* (Rokeach, 1964), where three hallucinating persons with Schizophrenia Spectrum Disorders all understood themselves to be Jesus Christ, posed a challenge at Ypsilanti State Mental Hospital. This project resulted in the understanding that the delusion of being Jesus Christ is a product of the Schizophrenia Spectrum Disorder, that there is no basis in religion or faith for their claim.

The challenge for the 55% of persons in the Baylor study is that if one is open to an active role for God, maybe there can be such a thing as a miracle. If there can be a miracle, and if one also believes in an active role for evil in the world, call it the Devil, then is this a belief in the mind of the beholder, or is there another dimension that is not being fully understood by DSM-5, one that might also change or expand the diagnosis?

Religion and spirituality are clearly a part of culture; the literature fully supports that. However, the elephant in the room is that there are also those who believe in an active God and if God is active, then how do we as social workers understand this role and thus support the client? Is culture a vessel large enough to contain all of the possible implications of religion and spirituality in this historic debate?

In the final book of the Harry Potter series (Rowling, 2009) Harry Potter has just been killed and ends up at a place he likens to King's Cross, only cleaner, and says to Dumbledore, "Is all this real or is it just in my head?" Dumbledore responds, "Of course it is in your head, but that doesn't mean it isn't real!" ❖

References

Association, A. P. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric.

Blackburn, S. (1999). *Think*. New York: Oxford University Press.

Cook, C. C. H. (2013). Controversies on the place of spirituality and religion in psychiatric practice. In C. C. H. Cook (Ed.), *Spirituality and religion in psychiatric practice*. Norwich: SCM Press.

Ellor, J. W. (2005). Spiritual and Religious Life. In L. W. Kaye (Ed.), *Perspectives on Productive Aging* (pp. 149-161). Washington, DC: NASW Press.

Ellor, J. W., & Kimble, M. A. (2004). The Heritage of Religion and Spirituality in the Field of Gerontology: Don Clingan, Tom Cook, and the National Interfaith coalition on Aging. *Journal of Religious Gerontology, 16*(1/2), 143-154.

Ellor, J. W., & McGregor, J. A. (2011). Reflections on the Words "Religion, " "Spiritual Well-Being" and, "Spirituality". *Journal of Religion Spirituality and Aging, 23*(4), 275-279.

Frankl, V. (1961). Religion and Existentialism. *The Gordon Review, 6*, 2-10.

Froese, P., & Bader, C. (2010). *America's four Gods: What we say about God and what that says about us*. New York, NY: Oxford University Press.

Kimble, M. A., & Ellor, J. W. (1996). *Interview with Arthur Flemming*. Center for Aging Religion and Spirituality. St. Paul, Minnesota.

Koenig, H., McCullough, M., & Larson, D. (2001). *Handbook of religion and health*. New York, NY: Oxford University Press.

Malefijt, A. D. W. (1968). *Religion and Culture*. Long Grove: Waveland Press, Inc.

Meyer, A., & Lief, A. (1948). *The commonsense psychiatry of Dr. Adolf Meyer*. New York, NY: McGraw-Hill Book Company, Inc.

National Interfaith Coalition on Aging (1980). A definition of spiritual well-being. In James A. Thorson & Thomas C. Cook (Eds.), *Spiritual well-being of the elderly* (pp. xiii). Springfield: Charles C. Thomas.

Renetsky, L. F. (1977). The Fourth Dimension: Applications to the Social Services. *Paraclete, 4*(2), 104-118.

Rokeach, M. (1964). *The Three Christs of Ypsilanti*. New York, NY: New York Review Books.

Rowling, J. K. (2009). *Harry Potter and the deathly hallows*. London: Arthur A. Levine Books.

Shorter, E. (2013). The history of DSM. In J. Paris & J. Phillips (Eds.), *Making the DSM-5: Concepts and controversies (pp. 3-20)*. New York, NY: Springer Press.

Rev. James W. Ellor, *Ph.D., D. Min., LCSW, DCSW***,** *School of Social Work Baylor University One Bear Place # 97320 Waco, TX 76798-7320. Phone: (254) 710-4439. Email: James_Ellor@baylor.edu.*

Key Words: social work, gerontology, religion, spiritual well-being, spirituality, God