# DIFFERENTIAL DIAGNOSIS BETWEEN SPIRITUAL EXPERIENCES AND MENTAL DISORDERS OF RELIGIOUS CONTENT

Revista Psiquiatria Clinica 2009; 36: 75–82.

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Abstract:
Context: spiritual experiences can be confused with psychotic and dissociative symptoms, oftentimes presenting a challenge for differential diagnosis. Objective: to identify criteria which allow the elaboration of a differential diagnosis between spiritual experiences and psychotic and dissociative disorders. Methods: a comprehensive analysis was made of the literature regarding the subject, in which 135 articles identified in the research of PubMed were examined. Results: among the papers analyzed, nine common criteria were identified that could indicate an appropriate distinction between spiritual experiences and psychotic and dissociative disorders. They are, in relation to the experience of the subjects: lack of suffering or functional impairment, short duration of the experience, critical attitude (doubts about the reality of the experience), compatibility with the patient's cultural background, absence of comorbidities, control over the experience, and personal growth over time and a helpful attitude towards others. These criteria are useful pointers suggesting a non-pathological spiritual experience; but there is a lack of well-controlled studies testing these criteria. Conclusions: these criteria proposed in existing literature, though reaching a

significant consensus among different researchers, still need to be tested empirically, and methodological approaches for future research on this subject are suggested.

Keywords: hallucination, dissociation, possession, trance.

## INTRODUCTION

Historically, since the middle of the 19th century, psychiatry has often despised, and even considered religious and spiritual manifestations pathological.  Freud (1) considered religion an obsessive neurosis.  The mystical experience has also seen as a psychotic episode (2) and as borderline psychosis (3).  The Diagnostic and Statistical Manual of Mental Disorders III makes 12 references to religion, all of them associated to psychopathology (4).

Other authors, however, presented different opinions.  Jung (5) saw in the mystical experience, the manifestation of a psychologically healthy experience.  Maslow (6) considered the “culminating experiences” the maximum expression of psychological health and well-being.  Hood (7) and Caird (8) ascertained that individuals that reported having had mystical experiences scored higher in terms of psychological well-being scales and lower on psychopathological scales than those of the control group.

Some authors suggested the importance of looking for differential criteria between what would be non-pathological spiritual experiences and what would be mental disorders of religious content. These authors’ contributions to this important subject were taken from literature and the present paper sought to present and discuss some criteria common to the majority of investigations.  Finally, we concluded that even though all the criteria presented a certain consistency, an extensive

investigation testing these criteria has not been performed until present, and methodological rules for this investigation, suggested by some authors, are presented.

## METHODS

PubMed was the database used in this study and the descriptors investigated were “dissociation”, “trance”, “possession” and “hallucination”.  The articles that presented extensive research and differential criteria between what could be considered a healthy experience and what could be considered a pathological experience were prioritized.

## RESULTS

Several authors have studied the relationship between spiritual experiences and pathological manifestations of the mind.  Mystics, clairvoyants, and spiritual mediums have challenged the understanding of mental health professionals and have made necessary an adequate differentiation between that which would be a healthy spiritual experience and what would be a psychotic or dissociative disorder with religious content.

In the beginning of the 20th century, William James (9), while investigating the experiences of mystical ecstasy, verified that these experiences, when healthy, had a short duration and brought beneficial effects to those who had experienced them.

Buckley (10) examined autobiographical accounts of individuals who had had mystical experiences and others who had had schizophrenic experiences.  He identified common and differential aspects in both.  He found the following common aspects in both experiences: elevation in the level of consciousness, the feeling of being transported beyond one’s own self, loss of differentiation between self and objects, time dilation, feeling of being surrounded by light and a strong sense of communion with the divine.  Characteristic of mystical ecstasy are the preservation of the structure of thoughts and speech, the predominance of visual hallucinations over auditory, great acuteness of the senses, stability of emotions and limited duration of the experience.  Whereas in a psychotic

episode, disruption of thought and speech structure, predominance of auditory over visual hallucinations, numbness of the senses, reduction of emotions combined with aggressive or sexual outbursts and an extensive duration of the experience are characteristic.

Lenz (11) emphasized the degree of certainty of the experience as criteria of mental health. In a healthy life experience, there is doubt as to the objective reality of the experience and in a mental disorder there is certainty of the reality.

Lukoff (12), and later Greyson (13), investigated the Near-Death Experience, seeking to differentiate it from psychopathological experiences.  In this experience, an individual reaches the point of seeing him or herself out of his or her body, meeting spiritual beings, and afterwards returning to his or her body. Lukoff noticed prior and distinct stressors in the NDE, as well as, previous good psychological function, an exploratory attitude in relation to the experience and the absence of interpersonal deficits, while Greyson, validating the healthy characteristics of NDE, such as those already presented by Lukoff, differentiated it from Post-Traumatic Stress Disorder, seeing in the latter the presence of intrusive memories, general reduction of interest in various activities, feeling of estrangement from others, restricted range of affect and a sense of a foreshortened future that were not present in NDE.

Oxman et. al. (14) also saw common and differential aspects in the reports of mystics and schizophrenics.  They chose publicly available reports, which had been written soon after the experience, in English, and which were sufficiently elaborate.  Common to both experiences were the abundance of fantasies and, as differential factors, they saw that the mystics dealt with encounters with God and religious feelings, while schizophrenics dealt with diseases and strong feelings of evil.

Sims (15) proposes that a healthy spiritual experience is compatible with a religious tradition. The individual understands the incredulity of others and is reserved in regards to discussing his experience with those whom he believes to be unsympathetic. The experience is described unemotionally with matter-of-fact conviction and finally, the individual usually feels that the experience implies some demands upon himself; while the pathological experience is revealed in

results that are compatible with the phenomenology and the natural history of mental disorder and there are other recognizable symptoms of mental disturbance.

Grof and Grof (16), based on their clinical experiences, created the concept of Spiritual Emergencies. These authors presented these experiences with a double meaning, made possible by the different meaning of “Spiritual Emergence” and “Spiritual Emergency”. “Spiritual Emergence” refers to the development of a spiritual experience that occurs without bringing about a disturbance of psychological functions, while the “Spiritual Emergency” is the uncontrolled occurrence of spiritual experience along with problems of psychological, social, and occupational function.

Grof and Grof (16) elaborated a comprehensive and detailed differentiation between the manifestations of a spiritual experience and a mental disorder. In the first case, the experiences do not bring about unpleasant sensations, conflicts or the necessity of frequent arguing, but are tranquil and gradual, preserving the differentiation between what is inside and what is outside, creating an attitude of positive expectation, favoring a renouncement of control, stimulating the acceptance of change, integrating the experiences with a day-to-day awareness and allowing a detailed consciousness, thereby making possible a slow change towards the understanding of oneself and the world. Conversely, the experiences associated with a mental disorder are intense, creating unpleasant sensations such as tremors and shivers, are conflicted and abrupt, not differentiating what is internal from what is external, creating an ambivalent attitude, promoting the necessity to control, encouraging the resistance to change, bringing about disturbances in daily consciousness, confusing one’s comprehension and creating a necessity to discuss the experience, while promoting abrupt modifications in one’s own consciousness and perception of the world.

Greenberg and Witztum (17) investigated a population of orthodox Jews, seeking to differentiate what would be a rigorous but psychologically healthy system of beliefs and practices from an obsessive-compulsive disorder with a religious background. As such, healthy personal experiences are compatible with the beliefs accepted by the religious group, its details do not exceed the accepted beliefs, being moderated, creating excitement and social abilities and hygiene habits are preserved. However, in the obsessive beliefs, the experiences are very personal and diverge from the beliefs of the group; its details exceed the accepted beliefs, are intense, create terror and social

abilities and hygiene habits are compromised. Thus, healthy behaviors do not exceed the prescribed norms and are commonplace, obsessive checking and cleaning behavior is not present, and the disregard of other practices does not occur. Compulsive behavior, on the other hand, exceeds the norm, is very specific, being associated with cleaning and verification routines, disregarding other religious practices proposed by the religious group.

Lukoff et. al (18) proposed in the 1994 version of the Diagnostic and Statistical Manual of Mental Disorders (19), a new category of psychological problems, named Religious and Spiritual Problems. Religious problems are disturbing experiences involving the beliefs and practices of a church or religious institution, that occur, for example, during a crisis of faith or in a migration to a new religious orientation. Spiritual problems are disturbing experiences that involve the relationship of an individual with a transcendent being or force that occurs, for example, in mystical experiences and in near-death experiences. In a mystical experience, the following occurs: an experience of union with a divine being, great euphoria, and loss of notion of time and space, which can be confused with acute psychotic episodes (12). In a near-death experience, a person sees himself projected outside his body, finds spiritual beings and reaches a new understanding of life; this experience can be confused with a dissociative depersonalization disorder (20).

This was an important advancement in psychiatry, because it caused many spiritual and religious experiences to be accepted as non-pathological, although they may share some similarity to mental disorders. As its objectives, the creation of this category was to increase specifics in the diagnosis of these experiences, reduce damaging effects of misdiagnosis, and stimulate research that creates more adequate treatments for these problems and stimulate the centers of psychiatric training to add understanding and the treatment of these problems to their programs.

Jackson and Fulford (21) undertook a study comparing 5 individuals who had had spiritual experiences with 5 individuals who were recovering from psychotic outbreaks, but were interpreting their experiences in religious terms. They proposed that the spiritual and psychotic experiences cannot be differentiated only by the symptoms which are very similar from one case to another, but that it would be of greater importance to investigate the value system and beliefs with which the individual evaluates and understands his experiences.

Jackson and Fulford (21) were able to gather differentiating features between the two experiences. Therefore, the spiritual experience is generally: directed towards others, short lived, intellectually vivid, there are doubts regarding it, the insight of the internal origin of the experience is preserved, it is controlled, does not lead to loss of contact with reality, it is emotionally neutral or positive (brings satisfaction), brings awareness as to its incomprehensibility by others, flaws in intentional actions do not occur, it does not negatively affect life, its content is acceptable by the cultural reference group of the individual and promotes personal growth. Whereas, the psychotic experience is generally: directed towards the person himself, is long-lived, experienced physically, there is a certainty about it, a lack of insight regarding its internal origin, drives the individual to be submerged in it, suffering a loss of contact with reality, it is emotionally negative (causing suffering), a lack of consciousness of the incomprehensibility by others, creates flaws in intentional actions, deteriorates quality of life, its content is strange to the cultural reference group of the individual and a general loss occurs in their personal life.

Koenig (22), commenting on the medical literature about the differentiating criteria between spiritual experiences and mental disturbances, proposed that the former do not impair social or occupational performance, do not disrupt the relationship with a social-cultural reference group, and are not associated with other mental pathologies, promoting psychological growth with time.

The question of mental health and of psychopathology becomes critical when dealing with the hallucinatory phenomena that are habitually associated to schizophrenia or other psychotic states. According to Esquirol, hallucination is perception without an object (23). The definition of DSM IV does not differ much from this original meaning when defining hallucination as a sensory perception that presents a strong feeling of real perception, but occurs without the external stimulation of the relevant sensory organs (19).

Population surveys have indicated for more than a century that hallucinatory phenomena, are more than a category of experience restricted to psychotic schizophrenics, occurring often in general population. At the end of the 19th century, Sidgewick (24), affiliated with the Society for Psychic Research, along with a large number of collaborators, interviewed 7,717 British men and 7,599

British women. He verified that 7.8% of men and 12% of women reported having had at least one vivid hallucinatory episode. West (25), 50 years later, on a similar survey through the distribution of questionnaires among 1519 subjects in the same area previously investigated by Sidgewick, confirmed the occurrence of hallucinations in 14% of the individuals investigated.
Tien (26) proved that 10% of men and 15% of women from a sample of 18,572 individuals, obtained in a comprehensive survey of psychiatric symptoms in a general population (Epidemiological Catchment Area Program), had hallucinations throughout their entire lives with presenting other pathological symptoms. Ohayon (27) consulted 13,057 individuals from Great Britain, Germany, and Italy by telephone and proved that 38.7% of them reported having had hallucinations. Out of these, 5.1% reported having had them one or more times a week.

Besides the extensive occurrence of hallucinations, Johns and Van Os (28), Serper et. al. (29) and Lincoln (30) proposed that they happened in a continuum in which, at one end, there are healthy individuals and at the other, schizophrenics. Based on large population studies, they proposed that, since schizophrenia is not a categorical but a dimensional construction, there is more than one category of real schizophrenics, different from healthy people. Schizophrenia extends itself to a higher or lower degree in all populations. The pathological diagnosis depends on a higher frequency and intensity of the hallucinatory experience, the coexistence of other symptoms and on general adaptation ability setbacks.

Strauss (31) proposed that indicators of pathology could be the certainty of the objective reality of the hallucinatory experience, the absence of cultural support for the experience, a large quantity of time involved with the experience and the implausibility of the experience in relation to the socially shared reality.

Slade (32), investigating two small groups of psychotics (hallucinating and non-hallucinating) and Richardson and Divvo, (33), examining two groups of alcoholics (hallucinating and non-hallucinating), using psychological tests, verified that hallucinations are generally triggered by personal stress, in extremely self-focused people who are very imaginative and have a poor sense of reality. Honig et. al. (34) compared groups of non-hallucinating patients, patients with dissociative disorders, and schizophrenic patients, and concluded that the hallucinations among the normal

patients are calm, creating neither alarm nor perturbation and there control over them. The hallucinations of the schizophrenics are preceded by traumatic events, create perturbation and there is no control over them. Serper et. al. (29) compared three groups of people: 39 hallucinating schizophrenics, 49 non-hallucinating schizophrenics, and 363 normal college students and defined some characteristics of hallucinating schizophrenics: they think that their visual and auditory hallucinations are objective perceptions, they have various setbacks in life, and present other clinical dysfunctions and distorted perceptions.

Dissociative experiences have also been associated with mental disorders. The term “dissociation” was initially created by Pierre Janet in 1880 to mean “psychological disaggregation” (35). According to this author, dissociation would be a loss of unity in the functioning of human personality, in which certain mental functions act in an independent way and outside of conscious control. Dissociation can occur naturally when, for example, a person absorbs oneself in watching a movie and remains totally aloof from everything that is happening to himself or in his surroundings.

In the original concept of Janet, dissociation would be a categorical construction, or rather, a type or category of experience that occurs only in mentally ill individuals that have a deficiency in integrating different psychological contents. Some contemporaries of Janet, like Frederic Myers, Morton Prince and William James, presented a different point of view, in which dissociation is understood as a dimensional construction, or rather, is lived in a higher or lower degree by all people going from a healthy to a pathological extreme (36).

It is necessary to understand the extent to which dissociation occurs in the general population. Ross et. al. (37) evaluated a sample of 1,055 undiagnosed adults extracted from a total of 650,000 habitants of the city of Winnipeg, Canada. They applied this sample to the DES (Dissociative Experience Scale), an instrument of self-evaluation composed of 28 items, which measures dissociative experiences and proved that 13% of these individuals presented a score over 20, indicating the existence of a high level of dissociative experiences in this sample.

Waller et. al. (38) and Martinez-Taboas (30) proposed that non-pathological dissociation involves the capacity of absorption and imaginative involvement and constitutes a human experience to

which all individuals are prone, in a higher or lower degree. Tellegen and Atkinson (40) defined absorption as a state of complete attention in which the mind seems to be totally dedicated to experiencing the perceived object. Wilson and Barber (41), Rhue and Lynn (42), and Rauschenberger and Lynn (43) indentified some individuals, whom they called "fantasizers," who are very partial to fantasy, having had in their childhood a greater involvement with fantasy games rather than games with other children and their capacity to fantasize offered a means of escape from their loneliness and anger.

Lewis-Fernandez (44) affirms that non-pathological dissociation occurs with control by the individual, within an organized cultural context which is significant for that person and others. Butler et. al. (45) added that healthy dissociation is useful in the entire mental process, facilitating automatic actions and attitudes, assisting one in mentally escaping unpleasant situations and concentrating on absorbing activities. Its origin is not associated with trauma, it occurs in short periods, does not cause disturbance and does not block mental function.

Meanwhile, the propensity to fantasize, though it may look innocent, can come to pathological dissociations, when a traumatic event makes an individual find a way of escaping an intolerable reality by means of the fantasy (46). Pathological dissociation, though initially appearing as a way of dealing with an adverse situation; can be generalized for the rest life's situations, coming to harm the individual's capacity for adaptation (45). It is the interaction between the natural ability for absorption with traumatic experiences that results in pathological dissociation (45).

Pathological dissociation expresses a definite poor psychological functioning, creates suffering and incapacitation, is involuntary, and is interpreted by the cultural group of reference of the individual as being a disease that needs treatment (44). Pathologically dissociative individuals confuse non-pathological forms with pathological forms of dissociation (47). Pathological dissociation is still associated with traumatic experiences in the past, is chronic, serious, and debilitating to the psychological and social functioning of the individual (45).

According to Waller et. al. (38) and Martinez-Taboas (39), pathological dissociation expresses itself through amnesia, depersonalization-derealization, confusion and alteration of identity.

Dissociative Amnesia is basically understood as the loss of memory, especially of recent events and important personal information, which cannot be attributed to common forgetfulness, fatigue, or a symptom of organic origin (48).

Depersonalization refers to the affective alterations and perceptions related to self, which brings the individual to alienation from himself and his own body. Derealization refers to the same alterations in relation to one’s environment, which makes the individual feel uncomfortable in that environment (48).

Dissociative Identity Disorder, previously known as Multiple Identity Disorder, reveals itself in the presence of two or more distinct identities or personality states in the same individual which alternate in taking control of the person's behavior, with periods of amnesia eclipsing the personalities that were distanced (48).

The alteration of identity is also evident in the Dissociative Trance Disorder. Cardeña et. al. (48) defined trance as a temporary alteration of the consciousness, identity, or behavior, with the diminishing of the perception of the environment and occurrence of movements that are experienced as being beyond one's control. The same authors define Trance of Possession as being the same experience, with the difference that the alteration of consciousness is attributed to an external force or spiritual being that takes possession of the consciousness of whom is experiencing it.

One should be careful to not consider all of the forms of trance and possession as pathological, since Bourguignon (49), in an anthropological investigation, ascertained that in 488 societies in the world, 90% of them have institutionalized forms of trance, wherein 52% of those, these states are attributed to possession by spiritual beings. This, showing the extent to which this experience occurs in the world, leads us to be careful so as not to reduce it to a mere psychological malfunctioning of mentally ill individuals.

Lewis (50) proposed some criteria to differentiate between healthy and pathological possession. Non-pathological possession which he calls “central,” is episodic, occurs for a limited time, is organized and occurs inside a cultural context that gives it significance. However, pathological possession, which he calls “peripheral,” tends to be chronic, occurs in an uncontrolled way, is not organized and is not compatible with the cultural context in which the individual is integrated.

Beng-Yeong (51) proposes that healthy trance states would be triggered by defined actions, would be short-lived and create beneficial results for the individual who is experiencing them, and would be pathological if they were triggered by stressful emotions, lasted for a long time and created damaging results for those who experience them.

Cardeña et al. (52), utilizing the concepts of Lewis (50), affirm that central (non-pathological) possession probably comes from a biological predisposition, that was modeled by organized socio-cultural factors, that produced controlled rituals of possession. In this way we can understand the Possession Trances of mediumship that occur in spiritualistic religions, such as Spiritism, Umbanda and Candomble. Whereas peripheral (pathological) possession, while also arising from a biological predisposition, would have been impacted by physical or sexual traumas, thus creating alterations of identity that are difficult to control and organize.
These individuals come to present psychological suffering and significant harm to one’s social and occupational functioning.

DISCUSSION

We will present a summary of the principal differentiating criteria between a spiritual experience and a mental disturbance proposed by the revised authors authors. The order of presentation of these criteria stems from a decreasing level of agreement among the authors in regards to them, as presented in this paper. These criteria should not be considered in isolation, but as a whole. It is worthy of note that there is a scarcity of empirical studies that prospectively test the differentiating criteria of what would be a spiritual experience and what would be a mental disorder.

I - Lack of suffering (10, 12, 13, 14, 16, 17, 21, 32, 33, 34, 44, 45, 52).

Suffering is related to illness. We should remember, however, that the initial stages of a religious or spiritual experience can be accompanied by great personal suffering that can be overcome as the individual progresses in the comprehension and control of his experience. Greyson (13), studying Near-Death Experiences, affirms that the individuals, after the experience, feel anger and depression, experience shock in their religious beliefs, come to doubt their mental sanity, feel misunderstood by their families and health professionals, 75% end their marriages and their professional careers can be severely damaged. Commenting on 4 cases in his article, he affirms that adequate psychotherapeutic and psychopharmacological attention, brought about a better comprehension of their experience, allowing these patients to regain control and in many cases restructure their lives in a more significant way.

II – Lack of functional impairment (12, 16, 17, 21, 22, 28, 29, 30, 44, 45, 52).

Psychological health implies a structured ego, adequately generating social, family, and affective relationships and occupational activities. Meanwhile, Lukoff et. al. (54), comment on how individuals who have undergone a mystical experience can temporarily feel unadjusted in relation to their everyday lives, until they are able to comprehend the experience and return to their normal lives.

III – The experience has a short duration and occurs sporadically (9, 10, 21, 28, 29, 30, 31, 45, 50, 51).

The non-pathological Spiritual experience is an addition to the possibilities of life for the individual, not interposing itself with the remainder of the everyday experiences of the consciousness. It is expected for the healthy person to go through an uncommon experience and soon return to their habitual state of consciousness and everyday activities. However, there are cases of trained mediums who sustain spiritual experiences for a longer period of time without compromising their mental health (53).

IV – A critical attitude exists regarding the objective reality of the experience (11, 15, 16, 21, 22, 29, 31, 32, 33).

A healthy consciousness, surprised by the spiritual or religious experience, will need to reflect on the feeling for one's own self and life. As long as the individual does not develop a new comprehension of the experience that he is going through, he will need to consider this new

experience suspect, until it can be comprehended. Meanwhile, he may not be able to adequately evaluate what happened to him, as for example, in the mystical experiences shown by Lukoff et. al. (54).

V – Compatibility with the patient's cultural background (15, 17, 21, 22, 31, 44, 50, 52).

The compatibility of the experience with the beliefs and behaviors of a reference cultural group, suggests the social adjustment of the individual who experiences it, thereby validating it. Meanwhile, Near-Death Experience (13) and Mediumship (53) can surprise individuals and family members, as well as the religious groups in which they are a part of, without anybody having any type of comprehension as to what has happened.

VI – Absence of comorbidities (15, 22, 28, 29, 30).

Sims (15) pointed out that psychopathology related to a spiritual experience can be observed in the behavior of the individual as well as in his subjective experience, manifesting itself in all aspects of his life and creating a situation compatible with a history of a mental illness, bearing no resemblance to a spiritual experience. The more evident the pathology is, the greater the probability of a case of mental disorder.

VII – Control over the experience (21, 34, 44, 50, 51).

The control of one's everyday experience is up to a vigilant ego which guarantees good personal and social performance. It is also the responsibility of the ego to control religious and spiritual experiences, so as not to impair one's everyday life. Oriental methods of meditation, for example, might tend to attract individuals with borderline personality and narcissistic disorders, who have a fragile psychological integration, thus allowing the creation of false experiences of illumination full of terrifying visions in such individuals. (54).

VIII – The experience promotes personal growth over time (15, 16, 21, 22, 51).

The spiritual experience promotes enriching significance to the personal, social and professional life of an individual. However, the pathological experience, poorly structured from the outset, amplifies the disequilibrium of the individual over time, resulting in a general deterioration of the quality of life (15).

IX – The experience is directed towards others (21, 32, 33).

The experience, directed towards others, maintains a feeling and a social objective, indicative of a socially well-adjusted individual. This is contrary to the ego-centered experience, which tends to be isolating and can easily bring the individual to be entangled in a web of delirious thought, without that person being able to handle the extent of his deviation from normality.

## CONCLUSION

Although the differentiating criteria presented here suggest a way to differentiate a spiritual experience from a mental disorder, it is necessary to perform controlled studies that test these suggested criteria.

These future studies should be undertaken with care in order to retain greater validity:

1 – Tart (55), has already indicated the inadequacy of the traditional scientific approach to deal with “Altered States of Consciousness”, which he understands as qualitative alterations in the global standards of mental functioning that the individual feels to be radically different from his normal mode of functioning, recommending the extensive use of empirical observations that can be replicated by other researchers.

2 – Heber et. al. (56) and Ross and Joshi (38) propose that studies should be done with non-clinical populations, so that their results can be more generally applied to the non-diagnosed population.

3 – Reinsel (57) suggests that larger samples be used and that they be collected from environments where the studied experiences occurred with more frequency.

4 – Almeida and Lotufo Neto (58) recommend, among other things, that diverse criteria of normality and pathology should be used, the evaluation of the experience in a multi-dimensional way and prioritizing of longitudinal studies that allow the clarifying of the complex causal relations between the associated variables and the spiritual experiences and mental disorders.

5 – Levin and Steele (59) also insist on longitudinal studies, propose the use of operational concepts related to the experiences and recommend finding answers to the following questions: who, what, where, when, how, and why.

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