Curr Psychiatry Rep (2010) 12:174–179
DOI 10.1007/s11920-010-0117-7

Religion, Spirituality, and Psychosis

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Published online: 14 April 2010

Abstract This review discusses the relationships between religion, spirituality, and psychosis. Based on the *DSM-IV*, we comment on the concept of spiritual and religious problems, which, although they may seem to be psychotic episodes, are actually manifestations of nonpathological spiritual and religious experiences. Studies reporting that hallucinations also occur in the nonclinical population and thus are not exclusive to the diagnosed population are presented. Then, other studies pointing to the strong presence of religious content in psychotic patients are also presented. Finally, the criteria that could be used to make a differential diagnosis between healthy spiritual experiences and mental disorders of religious content are discussed. We conclude that the importance of this theme and the lack of quality investigations point to the necessity of further investigation.

Keywords Psychosis · Religion · Spirituality · Spiritual problems · Hallucination · Differential diagnosis

Introduction

To Koenig [1], religion is an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred and transcendent. Spirituality in turn would be a personal quest for understanding of the ultimate questions of life, about meaning, as well as the relationship with the sacred and transcendent. It would also involve being able to conduct or originate religious rituals and the formation of communities. Therefore, we understand that religion has a primarily social aspect, whereas spirituality bears a more personal sense and aspect. There has been increasing interest in the relationships between religiousness/spirituality and health. In the realm of mental health, hundreds of studies point out the association between religious involvement and lower levels of depression, suicide, and substance use/abuse as well as improved psychological well-being [2]. Nevertheless, the relationships between religiousness/spirituality and psychosis have not been explored in depth.

Some spiritual experiences may be confused with psychotic episodes, as they may involve experiences of external influences on thought and behavior, beliefs in delusional characteristics, and hallucinations—classic symptoms of schizophrenia, according to the *DSM-IV* [3]. On the other hand, psychotic patients frequently present with a symptomatology of religious/spiritual content. Furthermore, psychotic experiences can also occur in the nonclinical population [4]. These facts make necessary a better understanding of the relationships between religion, spirituality, and psychosis.

Religious and Spiritual Problems

The *DSM-IV* created a diagnostic category called religious and spiritual problems as a new focus of clinical attention, creating the possibility of assessing religious and spiritual experiences as part of a psychiatric investigation without prejudging them necessarily as psychopathological experiences. Lukoff et al. [5], the first proponents of these

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concepts, defined religious problems as conflicts regarding faith and doctrine (such as loss or questioning of faith, conversions), and spiritual problems as conflicts involving the relationship with transcendental matters or deriving from spiritual practices. As far as examples of spiritual problems, the authors mention the mystical experiences triggered by meditative practices, near-death experiences, and spiritual emergence/emergency.

According to these authors [6], mystical experiences bring out feelings of unity and harmonious relationship with the divine but can also involve a loss of the functioning of the ego, alterations in the perception of time and space, and the sense of lack of control over the event, which could be seen as psychotic symptoms. American clinical psychologists report that 4.5% of their patients describe these experiences in their therapeutic sessions. The near-death experiences happen to some people who were very close to death, had a feeling of being out of their bodies, felt transported to another part of space, and came back from it with their lives transformed. Studies show that up to one third of people who were close to death had that experience.

Those religious/spiritual experiences usually do not present major psychological difficulties for those who experience them, but they may in certain situations be distressing and lead to the search for assessment and medical or psychological treatment. In this case, they would be called spiritual or religious problems that are not necessarily mental disorders and instead may be just an adaptation of the patients to a new phase or life experience with potentially positive future effects.

Spiritual Emergence/Emergency

Among spiritual problems, the spiritual emergency is probably the one that brings the most difficulties for the differential diagnosis with psychotic disorders. Spiritual emergence is defined as critical stages of a deep psychological change that result in uncommon states of consciousness, intense emotions, visions, unusual thoughts, and several physical manifestations. A near-death experience, the birth or loss of a child, a divorce, financial ruin, as well as spiritual practices such as chanting religious hymns or doing meditation or yoga exercises may be triggering agents of spiritual emergences. Among the described modalities of spiritual emergence are shamanic initiatory crisis, psychic opening, and kundalini awakening. All these circumstances may provoke a deep alteration in the habitual psychological balance of an individual, forcing exteriorization of internal content until it is contained in the inner recesses of the consciousness [6, 7].

When this process occurs in an ordained and gradual way, the experience does not generate crisis, but when it occurs in a fast and chaotic way, it does cause a crisis. In this sense, there is a difference between spiritual emergence and spiritual emergency. The former refers to the spiritual unfolding of a spiritual potentiality without the disturbance of psychological functions, whereas the latter is the uncontrolled occurrence of a spiritual experience along with disturbances in psychological, social, and occupational functioning [6, 7].

Grof and Grof [7] made an ample and detailed differentiation between the manifestations of a healthy spiritual emergence and a mental disorder. In the first case, the experiences are mild and gradual, lack unpleasant sensations, preserve a differentiation between inner experience and external reality, generate a positive attitude of expectancy, integrate the daily consciousness, and make a slow change of understanding of the self and the world possible. Experiences connected to a mental disorder are intense and abrupt, generate unpleasant sensations, and bring about confusion regarding the differentiation between inner experience and external reality. This in turn generates an attitude of mistrust and resistance to experience, bringing disturbance into daily consciousness and provoking abrupt modifications in the consciousness of the self and the world.

Medical and psychiatric criteria also have been proposed to differentiate these categories of experiences. Organically, spiritual emergence happens in the absence of physical and brain diseases in an individual without psychiatric history and with organized psychological processes, communication skills, a cooperative attitude, and good social adjustment. Mental disorders, on the other hand, are associated with physical and brain diseases in an individual with a history of psychiatric problems; disorganized psychological processes; attitudes of shyness, paranoia, and aggressiveness; and deficient social adjustment [7].

The symptoms of spiritual emergency may be similar to those of the psychotic prodome, the period that precedes the onset of full-blown psychosis. The most characteristic symptoms of the prodome, such as visual and auditory hallucinations, paranoid attitudes, delusional thoughts, and social and occupational impediments, make this psychiatric diagnosis possible when the person presents with signs of a spiritual emergency [8–10]. Similar to when people are mourning and seem to be depressed but it is not a major depression, the spiritual emergency may look like psychosis, but it is not the same thing. Although spiritual emergencies may start as crises similar to the psychotic prodome, they should not be diagnosed as mental disorders because they can evolve into spiritual awakening in the end. From this awakening, the person may reach a more mature form; a sensation of deep connection with other people, nature, and the cosmos; as well as overall well-being and functioning [6].

Psychotic Symptoms in the Nonclinical Population

To elucidate the relationships between religion, spirituality, and psychosis, we next examine the prevalence of psychotic experiences in the general population so as to understand how much the mere report of an experience usually regarded as psychotic cannot by itself characterize an individual as schizophrenic or as having a mental disorder.

Although most available studies on hallucinations involve patients who have schizophrenia, for more than a century, research has demonstrated that hallucinatory experiences occur in many other situations and can be common even in the nonclinical population. At the end of the 19th century, Sidgewick [11]—linked to the Society for Psychical Research—and his collaborators interviewed 7717 men and 7599 women. They found that 7.8% of the men and 12% of the women reported at least one vivid experience of hallucination during their lives. Conducting a similar study with 1519 individuals more than 50 years later, West [12] confirmed the occurrence of hallucinations in 14% of those surveyed. Tien [13] found that 10% of the men and 15% of the women in a sample of 18,572 individuals from the general population had hallucinations throughout their lives without presenting with other pathological symptoms. Ohayon [14] investigated 13,057 people in Great Britain, Germany, and Italy over the telephone, observing that 19.7% of them reported having had hallucinations less than once a month, 6.4% once a month, 2.7% once a week, and 2.4% more than once a week. In short, based on several populational surveys, one can conclude that 10% to 25% of individuals in the general population have already had, throughout their lives, experiences in which they heard voices or had visions with no external basis for them [15].

People who hallucinate may develop a natural attitude regarding their hallucinatory experiences. Romme and Escher [16] verified that a successful adaptation to the voices may happen in three stages: the voices appear initially in times of emotional turmoil, generating anxiety. Then the individuals try to develop strategies to deal with the voices, until they eventually consider them part of themselves. Miller et al. [17] found that hallucinations can also yield positive effects in those who have them, including relaxation, company, and distraction therapy. In this case, they tend to continue even after a successful treatment.

Van Os et al. [18•] performed a systematic review with a meta-analysis of articles published from 1950 to August 7, 2007, looking for evidence of the existence of a continuum of psychotic symptoms in patients with psychotic disorders and in the nonclinical population. In the 47 articles reviewed, the median prevalence of psychotic experiences with clinical impact (associated with distress or help-seeking behavior, thus called *psychotic symptoms*) was 1.5% (interquartile range, 0.4%–3.0%). However, the median prevalence of psychotic experiences without clinical impact (not associated with distress or help-seeking behavior) was much higher: 8.4% (interquartile range, 3.5%–20.9%). Thus, this systematic review showed that *psychotic experiences* (with no clinical impact) are much more prevalent than *psychotic symptoms* (with clinical impact). This study also found that 75% to 90% of psychotic experiences are transitory, disappearing with time and not representing significant risks to the mental health of the people who had them.

We can also add that the frequent and intense occurrence of psychotic experiences is not always associated with mental disorders. In an investigation of 115 randomly selected spiritist mediums active in spiritist centers in São Paulo, Brazil, individuals reported frequent auditory and visual hallucinations as well as experiences of influence (eg, insertion of thoughts and feelings) [19, 20]. Although they presented with multiple psychotic experiences, the mediums showed a high level of education, low unemployment rate, good scores of social adjustment, and low scores in other psychiatric symptoms. This group presented with a lower prevalence of mental disorders than the general population. A relevant finding that deserves further investigation is the fact that a higher frequency of spiritual experiences (involving hallucinations and experiences of influence) was correlated with better social adjustment and fewer general psychiatric symptoms.

Religion and Psychosis

The connection between religiousness and psychosis has been verified historically. In the early times of psychiatry, Phillipe Pinel stated that religious fanatacism may be a causative factor of madness and that mad people should be deprived of the symbols and practices of their religion and taught philosophical and historical knowledge. Emil Kraepelin registered the very frequent presence of mystical and religious content in his psychotic patients, and Kurt Schneider noticed a heightened religiousness in depressive patients, especially among schizophrenics [21]. Sigmund Freud, in psychoanalysis, and G. Stanley Hall, in psychology, believed that religion was a factor that caused neurosis and that modern psychological theories would substitute for the old religious beliefs [22].

Farr and Howe [23] verified in the United States that one in seven psychotic patients was very worried about ideas and religious practices. Erinosho [24] found that in Nigeria, a large majority of 208 schizophrenic patients sought help from local healers before looking for psychiatric help. In

India, it was verified that good outcomes among 323 patients observed for 2 years were associated with an increase in patients' religious activities [25]. Dantas et al. [26] analyzed 200 admissions in the psychiatric ward of the State University of Campinas General Hospital, Brazil, and found that religious symptoms with moderate to very strong intensity were present in 15.7% of the cases. In Europe, a prevalence rate of 21.3% of religious deliria among German inpatients was verified, but the prevalence was only 6.8% among Japanese inpatients, demonstrating that different cultures produce different effects regarding religious delusions [27]. In the United States, Appelbaum et al. [28] verified that of a total of 1136 psychiatric inpatients, 328 had deliria, and 93 had deliria of religious content.

More recently, Mohr and Huguelet [29] found that religion may be present in the psychotic patients' lives as part of the problem as well as part of the solution. Therefore, whereas some patients may be strengthened by their religious beliefs and helped by the community to which they belong, others may feel overburdened by the spiritual activities and feel demoralized and rejected by them. Among 115 psychotic patients in Switzerland, 85% considered religion to be important in their lives, bringing hope to 71% but desperation to 14% [30]. Reassessing the same group of individuals in a 3-year follow-up, it was found that religiousness was stable for 63% of the participants, with 20% reporting positive changes and 17% reporting negative changes. The authors verified that these oscillations were due to fluctuations in self-esteem and quality of life among the schizophrenic patients, reflecting the internal conflicts they experienced in their personal lives [31••].

We conclude, agreeing with Wilson [32], that although religion cannot be considered an etiologic factor in schizophrenia, it influences the content of patients' thoughts and as a consequence their behavior and probably the outcome. Koenig [33] in turn stated that the religious delusions exist in a continuum, from the reasonable beliefs of healthy individuals to the delusional beliefs of psychotic individuals, and that the involvement in new religious movements may not only be the cause but also the consequence of psychotic symptoms.

Differential Diagnosis Between Spiritual Experiences and Psychotic Disorders

The multiple interrelations among religiousness, spirituality, and psychosis discussed in this article lead us to the matter of looking for criteria that could allow us to differentiate healthy spiritual experiences from psychotic mental disorders.

Several researchers have already discussed the pathological or healthy character of spiritual experiences. Jackson and Fulford [34] claimed that spiritual experiences and psychotic symptoms could not be differentiated only by the form or content of the symptoms, that it was also necessary to assess how much the values and beliefs present in the individual direct his or her actions constructively or destructively. Koenig [33] stated that the healthy religious individual has insights on the nature of his or her experiences, belongs to a group that shares his or her beliefs and experiences, does not have other symptoms of mental disorders, is capable of maintaining a productive job, is not involved with legal problems, does not harm himself or herself, and has a positive result with time. Lukoff [35] resumed the concept of spiritual problems with a new term: *spiritual visionary experiences*. Good prior functioning, a period of occurrence of experience of 3 months or less, a stressful precipitating factor, a positive exploratory attitude regarding the experience, and the absence of conceptual disorganization are indicators of a spiritual visionary experience. Hufford [36], also working with the concept of spiritual visionary experiences, claims that these experiences put the individual in direct contact with spiritual experiences, adding that a hallucinatory experience with insight is associated with a positive prognosis, as even though a perception disorder may be taking place, there is no judgment disorder associated.

Menezes and Moreira-Almeida [37••] made an ample revision of the criteria proposed in the literature for a differential diagnosis between spiritual experiences and mental disorders. The presence of these features would suggest that spiritual experiences might be considered nonpathological:

- Absence of psychological suffering: the individual does not feel disturbed due to the experience he or she is having.
- Absence of social and occupational impediments: the experience does not compromise the individual's relationships and activities.
- The experience has a short duration and happens occasionally: it does not have an invasive character in consciousness and in the individual's daily activities.
- There is a critical attitude about the experience: the capacity to perceive the unusual nature of the experience is preserved.
- Compatibility of the experience with some religious tradition: the individual's experience may be understood within the concepts and practices of some established religious tradition.
- Absence of psychiatric comorbidities: there are no other mental disorders or other symptoms suggestive of

mental disorders besides those related to spiritual experiences.
- Control over the experience: the individual is capable of directing his or her experience in the right time and place for its occurrence.
- Life becomes more meaningful: the individual reaches a more comprehensive understanding of his or her own life.
- The individual is concerned with helping others: the expanded consciousness develops a deep link with other human beings.

Conclusions

Although relationships between psychosis and religiousness/spirituality have been detected historically, this theme remains underexplored. Current research available in the field may be divided into two large groups: religiousness and its impact on psychotic patients and the topic of differential diagnosis between spiritual experiences and psychotic disorders. These aspects have attracted increased attention from clinicians and researchers. These interrelations are complex, making simplistic or generalized approaches impossible. Although there are many gaps, the existing knowledge assists in the better understanding of human experience and the promotion of more effective clinical, humanitarian, and sensitive care in the field of mental health.

Disclosure No potential conflicts of interest relevant to this article were reported.

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