Differential diagnosis between non-pathological psychotic and spiritual experiences and mental disorders: a contribution from Latin American studies to the ICD-11

Diagnóstico diferencial entre experiências espirituais e psicóticas não patológicas e transtornos mentais: uma contribuição de estudos latino-americanos para o CID-11

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Abstract

Objective*: To review research articles in psychiatry and psychology involving Latin American populations and/or produced by Latin American scholars to investigate the differential diagnosis between spiritual/anomalous experiences and mental disorders in order to contribute to the validity of the International Classification of Diseases towards its 11th edition in this area.* ***Method****: We searched electronic databases (PubMed, PsycINFO, Scopus, and SciELO) using relevant keywords (possession, trance, religious experience, spiritual experience, latin*, Brazil) for articles with original psychiatric and psychological data on spiritual experiences. We also analyzed the references of the articles found and contacted authors for additional references and data.* ***Results****: There is strong evidence that psychotic and anomalous experiences are frequent in the general population and that most of them are not related to psychotic disorders. Often, spiritual experiences involve non-pathological dissociative and psychotic experiences. Although spiritual experiences are not usually related to mental disorders, they may cause transient distress and are commonly reported by psychotic patients.* ***Conclusion****: We propose some features that suggest the non-pathological nature of a spiritual experience: lack of suffering, lack of social or functional impairment, compatibility with the patient's cultural background and recognition by others, absence of psychiatric comorbidities, control over the experience, and personal growth over time.*

Descriptors*: Psychotic disorders; Spirituality; Diagnosis, differential; Classification*

Resumo

Objetivo: Contribuir para a validade da Classificação Internacional de Doenças-11ª edição no diagnóstico diferencial entre experiências espirituais/anômalas e transtornos mentais revisando artigos de pesquisa sobre o tema em psiquiatria e psicologia envolvendo populações latino-americanas e/ou produzidos por pesquisadores latino-americanos. ***Método:*** Pesquisa em bases de dados (PubMed, PsycINFO, Scopus, and SciELO) por meio de palavras-chave (possessão, transe, experiência religiosa, experiência espiritual, Latin*, Brazil) em busca de artigos com dados psicológicos e psiquiátricos originais em experiências espirituais. Também foram analisadas as referências dos artigos selecionados e autores na área foram contactados em busca de dados e referências adicionais. **Resultados:** Há evidências consistentes que experiências psicóticas e anômalas são frequentes na população geral e que em sua maioria não estão relacionadas a transtornos psicóticos. Frequentemente, experiências espirituais envolvem experiências dissociativas e psicóticas de caráter não patológico. Embora as experiências espirituais não estejam habitualmente relacionadas a transtornos mentais, elas podem causar sofrimento transitório e são frequentemente relatadas por pacientes psicóticos. Conclusão: Propomos algumas características que sugerem a natureza não patológica de uma dada experiência espiritual: ausência de sofrimento, de prejuízo funcional ou ocupacional, compatibilidade com o contexto cultural do paciente, aceitação da experiência por outros, ausência de comorbidades psiquiátricas, controle sobre a experiência e crescimento pessoal ao longo do tempo.

Descritores: Transtornos psicóticos; Espiritualidade; Diagnóstico diferencial; Classificação

Introduction

There are increasing literature reports showing a high prevalence of psychotic,[*] dissociative, or other unusual experiences in the general population, but most people who experience such events do not have psychotic or dissociative disorders.[1-4] It seems that people who have psychotic experiences form a heterogeneous group, where some are affected by illness but not others. In fact, alterations of consciousness that could be interpreted as psychotic have been reported throughout history and interpreted as personally and socially valuable, and they

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continue to be sources of inspiration in the arts, literature, religion, and other areas.[5,6] Because most of the "received wisdom" about such experiences is based on clinical, often hospitalized samples, there is little understanding of the implications of these experiences in non-clinical populations. Many clinicians worldwide are not yet aware of recent findings in the general population and lack clinical guidelines to help them understand individuals reporting pseudo-psychotic or other unusual experiences not actually related to psychotic or other disorders. This situation creates a high risk of misdiagnosis and iatrogenic damage.

Another emerging field in psychiatry is the study of the relationships between spirituality and mental health. One topic that has been little explored in this field concerns spiritual experiences. From the clinical point of view, a better understanding of this subject is needed because some spiritual experiences may be confounded with psychotic episodes, since they involve visionary or transcendent experiences that might be taken as schizophrenia symptoms. On the other hand, psychotic patients may present with symptoms of a religious/spiritual nature.[7,8]

Because of these problems, the DSM-IV introduced the new diagnostic category of Religious and Spiritual Problems as a focus for clinical attention, justifying the assessment of religious and spiritual experiences as part of a psychiatric investigation without pre-judging them as necessarily psychopathological. Lukoff, Lu, and Turner defined religious problems as conflicts related to faith and doctrine (such as loss or questioning of faith and religious conversions), and spiritual problems as conflicts involving the relationship with transcendental matters or deriving from spiritual practices.[9] As examples of spiritual problems, the authors mentioned mystical experiences triggered by meditative practices, near-death experiences, and spiritual emergency (distress and dysfunction associated with the unfoldment of spiritual experiences). Such religious/spiritual experiences do not usually pose major psychological difficulties, but they may be distressing and lead to the search for assessment and medical or psychological treatment. In these cases, they can be understood as spiritual or religious problems that are not necessarily mental disorders and may just reflect one's way to adapt to a new phase of life or experience with potentially positive effects.[12] The view that some psychotic experiences such as hallucinations can be one of the stages of spiritual development, rather than a disorder, dates back to a long time.[13]

Based on the considerations above, we believe that it would be useful to include empirically-grounded guidelines in the differential diagnosis between spiritual experiences, non-pathological anomalous experiences, and actual pathological symptoms within the ICD-11. We reviewed research articles in psychiatry and psychology involving Latin American populations and/or conducted by Latin American researchers on the differential diagnosis between spiritual experiences that may resemble psychotic and/or dissociative symptoms and actual disorders. This review may contribute to the ICD-11 in several areas, including the classification of mental disorders in Latin America, and improve the worldwide applicability of mental disorders classifications, especially in what concerns schizophrenia and other disorders.

Method

We performed several searches in electronic databases. In PubMed, we used the search expressions "((((possession) OR trance) OR religious experience) OR spiritual experience) AND (latin OR brazil)," which resulted in 140 matches; in Scopus, a search including "ABS (possession OR trance OR religious experience OR spiritual experience) AND ABS (latin* OR brazil)" yielded 73 references; in SciELO, the Portuguese expressions "Transe OR possessão OR experiência religiosa OR experiência espiritual" returned 24 references; and, finally, the search performed in PsycINFO based on the terms "trance" and "spirit possession" resulted in more than 700 matches, most of which were not relevant to our review. The reference lists of the selected articles were checked for further relevant publications and authors were contacted for additional references and data. We focused on articles with original data regarding the psychiatric and psychological aspects of spiritual experiences, as well as on review papers with an emphasis on, but not limited to, Latin American populations. Finally, we performed a search in PubMed using the expressions "psychotic symptoms" and "general population" to find recent articles representative of the state of the art in this specific research field.*

Results

1. Psychotic experiences in non-clinical populations

A recent survey performed by the World Health Organization (WHO) involving more than 250,000 respondents in 52 countries found a high prevalence of psychotic experiences (defined as those occurring "when you were not half asleep, dreaming or under the influence of alcohol or drugs*") in the general population in the previous year: 12.52% in the total sample. There was, however, a wide prevalence variation across countries, ranging from 1% in Vietnam to 46% in Nepal reporting at least one psychotic experience. Among the seven Latin American countries included in the survey, the prevalence ranged from 5.5% in Uruguay to 32% in Brazil (Paraguay, Mexico, and Ecuador: 9%; Guatemala: 15%; Dominican Republic: 21%). Although related to a diagnosis of schizophrenia in only about 10% of the cases, the number of psychotic experiences correlated moderately with poor health status.[4]*

In a nationally representative sample of Latinos in the United States, the lifetime prevalence of psychotic experiences was 9.5%, but 93% of those reporting psychotic experiences had never had any diagnosed psychotic disorder.[14] However, reports of psychotic symptoms were related to higher emotional distress and disability, which the authors of the study interpreted more as a marker for general psychiatric morbidity (usually depression, anxiety, or substance misuse disorders)

* Although the term "psychotic" is typically used in reference to severe mental disorders, experiences usually considered psychotic, such as hallucinations, thought insertion, and experiences of passivity are not necessarily pathological. Such cases would probably be better grouped under a more neutral term like "anomalous experiences".[10] However, in this article, we opted to follow Jackson and Fulford's[11] suggestion and use the term "psychotic phenomena" or "psychotic experience" in a broader sense to refer to both pathological and non-pathological experiences. Henceforth, we will call a pathological "psychotic experience" a "psychotic symptom".

than for psychotic disorders. Remarkably, about 1/3 of those reporting psychotic experiences had no psychiatric disorders as assessed with a structured clinical interview. The lifetime prevalence of psychotic experiences was associated with seeking comfort through religious/spiritual means. A high prevalence of psychotic experiences (20.9%) was also reported among 1,005 patients in general medicine urban practice in the United States.[15] These experiences were more frequent among Hispanics and low-income patients, and were associated with a higher level of mental disorders (usually depression and anxiety) and disability.

2. Spiritual experiences and practices

Since the 19th century, psychologists and psychiatrists have tended to regard spiritual experiences as mental disorders and religious involvement as a marker of pathology or psychological immaturity,[9] with few exceptions, such as William James.[16] This approach was especially strong in the case of spiritual experiences that resemble psychotic and dissociative disorders, such as those occurring within Spiritism and African-American traditions, both of which are popular in Latin American countries. This inadequate psychiatric approach was a source of prejudice, segregation, and involuntary psychiatric hospitalizations.[17-19]

Idioms of distress (i.e., culturally specific ways of expressing illness or distress) and spiritual beliefs and practices among Latinos may further complicate the significance of psychotic experiences in these cultures. Thus, it is necessary to search for other markers of mental disorders to evaluate the clinical significance of reports of these experiences.[15,20] We present now studies, involving mainly Latin American populations, which evaluated criteria for a differential diagnosis. Given the scarcity of well-done studies, we also report findings obtained from other populations.

One way to recognize markers of the pathological nature of psychotic experiences is to identify features associated with the search for clinical care. Lovatt and coworkers compared a clinical sample of patients with psychotic disorders and a non-clinical sample of people reporting psychotic experiences (most of this non-clinical sample belonged to psychic or spiritualist associations) in the United Kingdom.[21] Both samples had the same total scores in a psychotic/anomalous perception measure; however, there were very important differences. The clinical group scored higher in cognitive-attention problems (thought blockages, attention deficits) and depressive and anxiety symptoms. Regarding anomalous/psychotic experiences, the clinical group was much more likely to make "other people" appraisals of these experiences (evaluating one's experiences as being caused by other people) [OR = 21]), and to consider these experiences more often as dangerous, negative, and anxiety-provoking. The non-clinical sample, on the other hand, regarded such experiences as normal and positive with a higher frequency. In summary, the groups did not differ in terms of the total score of anomalous/psychotic experiences, but they did differ in relation to specific types, appraisals, and responses to these experiences. The authors concluded that "appraising experiences as part of the normal range of human experiences therefore appears to be adaptive, whereas making paranoid and externalizing appraisals seems to be associated to a 'need for care'" (p.817). Similarly, people who report hearing voices but who have no psychological problems tend to differ from psychologically-affected patients in such variables as being able to control the experiences and more benign contents of what the voices say.[22]

Studies performed with individuals who practice Spiritism or reputed parapsychological techniques in Brazil, Argentina, and Peru have shown that these specific subgroups have a high prevalence of psychotic/anomalous experiences (visions, hearing voices, experiences of influence, thought transmission, etc.), but that these experiences have been related to higher levels of spirituality and better mental health, social adjustment, and well-being, rather than to pathology. These phenomena are often perceived as frightening in the beginning, but are usually later interpreted as having deep positive consequences (in terms of well-being, making life more meaningful, hope, spiritual beliefs, etc.) by those experiencing them.[23-25] Other authors have emphasized the potential beneficial effects of such anomalous experiences.[26-28]

Mediumship is a case in point. It can be defined as an experience in which an individual (the medium) purports to be in communication with, or under the control of, the personality of a deceased person or other non-material being. This experience, which is sometimes equivalent to willed spirit possession, has also been called channeling *and has been related to the production of a number of creative works in literature, music, and the arts.[29] Institutionalized forms of possession and similar forms of ritually-induced altered states of consciousness have been described in 53% of 488 societies around the world[30] and are ubiquitous in both Eastern and Western history.[31] At present, these experiences are widespread in Latin America and worldwide through religious groups that foster them, such as Charismatic Catholics, Pentecostals, Spiritists, and African-Americans religions.*

Koss-Chioino conducted an in-depth study on the integration of mental health care and Spiritist healers in Puerto Rico.[32,33] Regarding mediums, most of them were reported to have started seeing spirits (usually deceased relatives, angels or other friendly spirits) when they were children or teenagers, which had a positive effect in that the spirits gave help or emotional support in times of crisis. Although most parents accepted their children's experiences, some of them ignored them or interpreted them as emotional disturbances. Most of the mediums had never received mental health care or been diagnosed as mentally ill. All these mediums went through initiation processes in Spiritist centers in order to use their mediumistic skills to help others. The characteristics that the author identified as useful in differentiating this spiritual experience from mental disorders were the control over alterations in their state of consciousness and the enhancement of interpersonal skills (e.g., mediumistic practices used to heal others).

Negro and coworkers studied 110 individuals (60% of whom were mediums) attending courses at Spiritist centers in São Paulo, Brazil.[34,35] In Spiritism, all activities (including courses and mediumship) are free of charge and are understood as charitable enterprises. Although having high scores in dissociation, the mediums had good socialization and adaptation scores (education, work, and level of happiness), and low levels of childhood abuse. Mediumship training was associated with control over the experience, but not with

higher levels of mediumistic experience. Pathological dysfunction was related to less control of mediumistic activity, lower age, later inception of anomalous experiences, poorer social support, and more antecedent psychiatric symptomatology. Higher levels of mediumistic activity were related to lower scores of harm-avoidance (a personality dimension common in anxiety-prone individuals and characterized by pessimistic worry in anticipation of future problems and passive avoidant behaviors) and were not associated with reward-dependence (sentimentality, social attachment, and dependence on approval of others).

Our group performed a study with 115 mediums from randomly selected Spiritist centers in São Paulo, Brazil. The sample had a high socioeducational level, a low prevalence of mental disorders, and was socially well adjusted. Mediums reported high levels of psychotic and dissociative experiences (including an average of four Schneiderian first rank symptoms, symptoms that are often considered in the psychiatric literature as strongly suggestive of schizophrenia, but which are also found among individuals with dissociative disorders, such as audible thoughts or thought insertion). However, these experiences were not correlated with other markers of mental disorders such as social adjustment, common psychiatric symptoms (e.g., depression, anxiety, or psychosomatic complaints), and history of childhood abuse. Actually, incorporation (the experience of being fully possessed by another entity) correlated with better scores in social adjustment and fewer psychiatric symptoms. Hearing and psychography (or automatic writing) were also correlated with better social adjustment.[36-39] As compared with data from patients with multiple personality disorder, renamed dissociative identity disorder (DID), mediums had better social adjustment, lower prevalence of mental disorders, lower use of mental health services, no use of antipsychotics, and lower prevalence of histories of physical or sexual childhood abuse, sleepwalking, secondary features of DID, or symptoms of borderline personality.[38]

Usually, the mediumistic experiences reported had emerged in childhood and outside a receptive cultural environment (relatives and acquaintances often labeled such experiences as "craziness" or "demonic possession"), which caused distress and feelings of being different and socially isolated, although it is worth pointing out that the Brazilian culture is more open than most other cultures to these kinds of spiritual experiences. Only decades later in life are these experiences integrated as healthy spiritual events. At the time of the study, experiences like hearing voices, seeing spirits, and experiences of influence, although occurring more often in ritual settings, would also take place in daily life, outside ritual settings.[28,36]

In another investigation, Laria studied three groups of Cubans: spirit mediums, mental health patients, and a control group of non-mediums/non-patients.[40] Mediums reported higher rates of normal dissociative experiences, lower levels of psychopathology, fewer traumatic experiences (including sexual abuse), and less subjective distress than patients.

Reinsel found that a sample of North American mediums experienced more depersonalization and absorption than controls, but the two groups did not differ in regard to self-reported well-being or psychological distress.[41] In contrast, Seligman[42] proposed that in Candomblé *(an African Brazilian religion) mediums tend to somatize and to experience other disturbancesbut one limitation of this study was that she did not control for socioeconomic status as a potential confounder variable.*

In trying to make sense of anomalous experiences in general, some studies have investigated the profile of schizotypal symptoms (positive, negative, and disorganization) in the general population. Schizotypy has been defined as a multi-factorial personality construct, the aspects of which appear to be on a continuum with psychosis.[43] A three-factor model composed of positive (cognitive-perceptual anomalous experiences), negative (interpersonal deficits, physical and/or social anhedonia), and disorganization aspects has been proposed. Claridge described a class of "happy schizotypes", people who have unusual cognitive perceptual experiences unrelated to negative or disorganization factors. Positive schizotypy has been strongly correlated with paranormal beliefs and experiences.[43] In a sample of college students from Buenos Aires, Argentina, and Lima, Peru, "spiritual" students showed higher levels of paranormal experiences and of positive schizotypal symptoms than "non-spiritual" students. There was no difference regarding negative and disorganization symptoms.[24] Schofield and Claridge investigated participants of paranormal interest groups on the internet in the United Kingdom.[44] Cognitive disorganization moderated the association between schizotypy and subjective evaluation of paranormal experiences as pleasant or unpleasant. Having a belief framework that makes sense of positive schizotypal experiences had a protective effect, related to less cognitive disorganization and more pleasant paranormal experiences. The authors proposed that those without such buffering cognitive framework would be "bombarded by strange events for which they had no explanation" (p.1910) and be more prone to distress and poor functioning because such experiences would be frightening and disturbing. This may explain why the explanatory framework of various spiritual traditions may serve therapeutic purposes.[45]

A 20-year prospective study from Switzerland showed a high prevalence of psychotic experiences among people in their twenties, which decreased throughout the 20-year-long follow-up. In line with the dimensions of schizotypy, factor analysis of psychotic experiences generated two factors: one related mainly to hallucinations and experiences of influence, the other consisting of paranoid delusions and interpersonal deficiencies. These two factors had different patterns of predictors, course, and functional outcomes.[46]

3. Religious experiences among psychotic patients

A study with Puerto Rican women with severe mental disorders living in the United States showed that religion/spirituality were the most frequent contents of hallucinations, and that religious beliefs and practices were a source of meaning and coping with psychotic symptoms. Also, one of the most important and frequent findings was the inability of clinicians to recognize and address the significance (often religious) of these psychotic experiences to patients and the need to evaluate religious history in the initial assessment of patients.[47] The importance of taking into consideration spiritual beliefs and even developing an alliance with religious/spiritual groups to treat patients

has been illustrated by other reports of psychotic patients in Puerto Rico[28,32,33,39] and Switzerland.[48]

The importance of religious issues to psychotic patients was also revealed in Brazil by an ethnographic study involving 21 young first-episode psychosis patients seeking care at an emergency psychiatric outpatient unit in São Paulo.[49] In almost all cases (20), patients and their families had sought religious sources of help (usually Pentecostal or Umbanda*, an African-Brazilian religion) in parallel with psychiatric resources.*

Conclusion

In the last decade, it has become clear that psychotic experiences are highly prevalent in the general population, and that in around 90% of the cases they are not associated with psychotic disorders. Calling these experiences "psychotic symptoms" would produce about 90% of false positives.[14] We believe that other terms proposed in the literature, such as "psychotic experiences"[11] or the more neutral "anomalous experiences," would be more adequate to describe these phenomena.[10]

In a recent paper, Van Os suggested a global reframing of our understanding of psychotic symptoms and disorders. He proposed linking psychosis to normal human experience because psychotic disorders are related to experiences also shared by the general population. The author emphasized how much we still do not know about such experiences and the need for a more humble approach in this area[50] (see Bentall[22] for more on hallucinations). Evidence of a high prevalence of psychotic experiences in the general, non-clinical population and several other recent research findings have fueled sophisticated criticisms of the current concepts of schizophrenia and the diagnostic criteria used by the ICD-10 and DSM-IV.[51,52] The findings argue for more evidence-based conceptualizations and diagnostic criteria for schizophrenia, as synthesized in statements such as "There is a significant gulf between the tradition on which DSM-IV schizophrenia is based and the knowledge that has accumulated in the recent decades (…)" and "There is a huge divide between findings formulated in contemporary theories of schizophrenia and the (nonevidence-based) way psychosis is conceptualized in DSM" (p.409, 413).[52]

Recognition by clinicians and the general population that psychotic experiences are very prevalent and not necessarily pathological may not only improve clinical practice, but also contribute to decrease the stigma associated with psychotic disorders, based on the wrong assumption that they are something completely different from common human experience.[22,50,51] Castillo,[27] in a review about psychosis and culture, proposed that psychotic episodes can be shorter and have better outcomes in cultures that respond to them with "sympathy, social support, and traditional healing practices" (p.15), in part because these factors may trigger lower levels of expressed emotion and provide a framework to understand such experiences and strategies to decrease their negative effects. In a more individualistic and biologically-oriented society, the sense of rejection, social isolation, and hopelessness derived from the expectation of having a chronic and incurable disease may contribute to worsen outcomes.

Epidemiological data strongly suggest that people having psychotic experiences form a heterogeneous group in which some suffer from health disorders but not others, as suggested by studies on psychotic experiences in relation to spiritual experiences.[34,37,38,53] From a clinical perspective, it is important to keep in mind the balance between two extreme poles: considering all anomalous experiences as markers of psychotic or even non-psychotic mental disorders on the one hand, or regarding them as irrelevant to our understanding of a patient's condition on the other.[20,54]

Over the last decades, empirical data have emerged showing that religious involvement and spiritual experiences are usually related to positive health outcomes.[55,56] As stated by the proponents of the DSM-IV's Spiritual or Religious Problems, "the clinician's response can determine whether the experience is integrated and used as a stimulus for personal growth, or whether it is repressed as a bizarre event that may be a sign of mental instability" (p.679).[9] Overall, cross-cultural studies show that people experiencing spirit possessions, glossolalia, and similar practices within a ritual context do not have higher pathology rates than comparison groups, and in some cases they actually seem to do better despite having occasional histories of trauma or major distress, suggesting that these practices may serve a healing purpose.[26]

The association between spiritual experiences and normal or even better levels of mental health and social adjustment do not corroborate the view that mediumistic experiences are less severe symptoms on a continuum with dissociative or psychotic disorders. If this were the case, a directly proportional correlation between the intensity of mediumistic experiences and psychiatric disorders or social maladjustment would have probably been found.[37] These assertions do not reflect, however, unwilled and uncontrolled types of possession that may cause distress and dysfunction.[26]

To improve cultural sensitivity, diagnostic manuals consider that dissociative experiences must cause distress, dysfunction, and lack indigenous sanction in order to be labeled as pathological.[1,57] Although useful, these criteria are not comprehensive nor can be used automatically. For instance, spiritual experiences (whose outcome shows that they are actually non-pathological experiences) may emerge in cultural environments that do not accept them, causing a significant amount of distress to those involved.[36]

When dealing with individuals from different cultural backgrounds, clinicians and researchers should try to learn what is the "emic" (i.e., culturally intrinsic) meaning and significance of any given experience, and not be guided only by a "universalist," general perspective (i.e., "etic"). Even religious groups recognize that actual psychiatric or neurological disorders have been too often mislabeled as spiritual experiences, postponing adequate treatment.[36,39,58,59] Misdiagnoses may be made in both directions by clinicians and spiritual leaders, highlighting the need for more sophisticated, unbiased, and empirically-based directions to support our clinical reasoning. We have lacked empirically grounded guidelines to make the differential diagnosis between healthy spiritual experiences and mental disorders.

One limitation of this article is the scarcity of good studies designed specifically addressing the matter in question, but the convergence of data provided by different authors with different populations allows us to draw relatively reliable conclusions and recommendations. We

have discussed guidelines for differential diagnosis elsewhere,[60,61] and additional considerations as those that can emerge from longitudinal evaluations are still necessary.[62] Based on the currently available knowledge, it would be useful to include information related to the differential diagnosis between spiritual experiences and mental disorders in the ICD-11. Clinicians and researchers should consider that it is important to:

- Acknowledge the importance of cultural competence in dealing with patients reporting spiritual experiences and develop this competence and clinical reasoning to make the differential diagnosis between spiritual experiences and mental disorders. This should help reduce the occurrence of iatrogenic harm by avoiding the risk of pathologizing healthy behaviors and extend the cross-cultural relevance of the ICD-11;

- Recognize that dissociative, psychotic, and other unusual experiences are not necessarily pathological, although they may cause distress if the surrounding environment is not receptive to them or, at least, does not provide a non-pathological framework for their occurrence and interpretation;

- Stimulate research that shall advance our knowledge in regard to spiritual experiences, improving our understanding of their nature (e.g., prevalence, precipitating factors, phenomenology, outcome) so as to perform adequate differential diagnoses and clinical management as needed.

Although most of this article is based on contributions from Latin America, the issues discussed here are not only relevant to ethnic minorities or exotic lands, a common misconception of cultural psychiatry,[63] but are also relevant to clinical practice worldwide, since surveys have shown high levels of psychotic experiences in association with religious beliefs and religious involvement throughout the globe.[4,13,64] This is another important reason to include at least a brief discussion on the subject in the ICD-11, which is intended to serve all countries in the world.

Given the increasing recognition of the importance of religiousness and spirituality and their implications for diagnostic assessment and therapeutic planning, several medical organizations recommend evaluating spiritual/religious history and practices during clinical assessments.[65,66] Obtaining this history from patients reporting psychotic experiences shall not only increase diagnostic accuracy and avoid the labeling of spiritual experiences that may be healthy as pathological, but shall also help clinicians to deal better with psychotic patients.

Recommendation

We recommend that the ICD include a text along the lines proposed below.

Considering that spiritual and religious beliefs and experiences can affect mental health and the way patients cope with distress and mental disorders, and that healthy spiritual experiences may present characteristics similar to those of dissociative and psychotic symptoms, it is good practice to inquire about patients' spiritual and religious background, beliefs, practices, and experiences.

It is crucial to develop cultural competence and clinical reasoning to understand the person's cultural frame of reference and to analyze the clinical relevance of experiences that may resemble dissociative and psychotic symptoms. Clinicians must become aware that most people reporting anomalous, psychotic, or dissociative experiences do not actually have psychotic or dissociative disorders. Certain features (Table 1), although not necessarily present or sufficient on their own, are suggestive of the non-pathological nature of such experiences. Whereas pathological counterexamples can be found for all of them (e.g., catatonic episodes without psychological suffering), the variables described in Table 1 generally speak against the presence of psychopathology. The more elements present, generally speaking, the less likely is the experience to be psychopathological.

We recognize that these guidelines impose some demands on clinicians, yet doing less would result in ignoring a mounting set of data and, more importantly, in the possibility of causing harm rather than good.

Table 1 - Guidelines to assess the clinical significance of spiritual, psychotic, or dissociative experiences

- Absence of psychological suffering: the individual does not feel disturbed by the experience he/she is having.
- Absence of social and occupational impediments: the experience does not impair the individual's relationships and activities.
- The experience has a short duration, happens only occasionally, and does not have an unwilled, invasive character in the individual's consciousness or daily activities. There are some experiences that may have a long duration but can be seen as a stage within the previous spiritual development of the person.
- There is a discerning attitude about the experience that includes the capacity to perceive its unusual/anomalous character and the insight that it may not be shared by others.
- Compatibility with some religious tradition: experiences might be understood within the concepts and practices of some established cultural or religious practice, even if it is not the local tradition.
- Absence of psychiatric co-morbidities: absence of other mental disorders or symptoms suggestive of mental disorders besides those related to spiritual experiences. Regarding psychotic experiences, although there may be reports of hallucinations or unusual beliefs, there is a lack of negative or disorganization symptoms.
- Control over the experience: the individual is capable of limiting his/her experience to the right time and place for its occurrence, for instance, within a ritual rather than at work or school.
- The experience promotes personal growth over time: improvements in the personal, social, and professional life of an individual. It is directed towards self-integration and helping others.

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** Modest*
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For more information, see Instructions for Authors.

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