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On the Intricate Relationship between Religious Conversion and Psychosis

Dr. Szabolcs Kéri

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The relationship between religious conversion and psychosis is one of the fundamental issues at the meeting point of theology and clinical psychology. In the present study, we present the main lines of research on this relationship emphasizing the similarities and differences between emotionally turbulent religious conversion and psychosis. Some basic experiences in perception, thinking, and feeling share the same roots in these conditions. Perplexity (e.g., ambivalence, inability to discriminate between own feelings, and hyperreflectivity) and self-disorder (e.g., depersonalization, impression of a change in one's mirror image, and experience of discontinuity in own action) may be similar in psychosis and religious conversion, whereas other features (e.g., negative symptoms, social withdrawal, disorganized thinking, and persistent delusions) may be different. Regarding the content of religious thought, conversion is characterized by unique themes in contrast to psychosis. The main doctrinal focus of conversion is laid on the destruction and death of the old self, new life and resurrection by baptism into the death of Jesus Christ, and the transformative work and gifts of the Holy Spirit. In summary, perplexity, self-disorder, and emotional turmoil are common features of turbulent religious conversion and psychosis, but a broader emergence of anomalous subjective experiences and cognitive deficits are detectable only in psychosis.

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The relationship between religious conversion and psychosis is one of the fundamental issues at the meeting point of theology and clinical psychology. In the present study, we present the main lines of research on this relationship emphasizing the similarities and differences between emotionally turbulent religious conversion and psychosis. Some basic experiences in perception, thinking, and feeling share the same roots in these conditions. Perplexity (e.g., ambivalence, inability to discriminate between own feelings, and hyperreflectivity) and self-disorder (e.g., depersonalization, impression of a change in one's mirror image, and experience of discontinuity in own action) may be similar in psychosis and religious conversion, whereas other features (e.g., negative symptoms, social withdrawal, disorganized thinking, and persistent delusions) may be different. Regarding the content of religious thought, conversion is characterized by unique themes in contrast to psychosis. The main doctrinal focus of conversion is laid on the destruction and death of the old self, new life and resurrection by baptism into the death of Jesus Christ, and the transformative work and gifts of the Holy Spirit. In summary, perplexity, self-disorder, and emotional turmoil are common features of turbulent religious conversion and psychosis, but a broader emergence of anomalous subjective experiences and cognitive deficits are detectable only in psychosis.

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II. SELF-TRANSFORMATION IN CONVERSION AND PSYCHOSIS

Religious conversion, i.e. adopting and intensifying of religious beliefs, values, and practices that were not the part of the life of an individual, is often hard and painful (Paloutzian, 2005, 2014; Pargament, Murray-Swank, Magyar, & Ano, 2004). Inspired by the classic model of William James, which distinguished the gradual conversion of “healthy-minded” and the sudden conversion of the “sick soul” (James, 1902), Leon Salzman, the founder of the American Academy of Psychoanalysis and Dynamic Psychiatry, postulated that a real development is always reasoned and thoughtful (Salzman, 1953). In Christian theology, *metanoia* (repentance) refers to a fundamental and profound change in inner life and observable practice and behavior (Boda & Smith, 2006). The relationship between conversion and repentance was specifically emphasized in the theology of John Calvin: “The term repentance is derived in the Hebrew from conversion, or turning again; and in the Greek from a change of mind and purpose; nor is the thing meant inappropriate to both derivations, for it is substantially this, that withdrawing from ourselves we turn to God, and laying aside the old, put on a new mind. Wherefore, it seems to me, that repentance may be not inappropriately defined thus: A real conversion of our life unto God, proceeding from sincere and serious fear of God; and consisting in the mortification of our

flesh and the old man, and the quickening of the Spirit.” (Calvin, 1536/2016)

The differentiation between spiritual crisis and psychosis is of particular relevance (Crowley, 2006; Gale, Robson, & Rapsomatioti, 2014; Group for the Advancement of Psychiatry (GAP), 1976; Harnack, 2011, 2012; Jackson & Fulford, 1997; Mitchell & Roberts, 2009; Mohr & Huguelet, 2004). In his classic essay on the diagnosis of prepsychotic schizophrenia, Meares (1959) noted that sensitive and introverted people often display sudden changes in religious attitudes, which is not the consequence of genuine experiences and transcendent maturation, but merely the projection of inner psychological uncertainty and a lack of integrity in the building blocks of personality. However, in addition to religious changes, several diverse phenomena characterize prepsychotic schizophrenia, including affective and social withdrawal, anxiety, inappropriate emotional responses, symbolic, literal, and predelusional thinking (ideas of reference), devaluation of reality, lack of propriety of behavior, and mannerism (Fusar-Poli et al., 2013; Klosterkötter, Hellmich, Steinmeyer, & Schultze-Lutter, 2001; Meares, 1959; Schultze-Lutter et al., 2012).

The psychopathological nature of conversion remained controversial in early research (Scroggs & Douglas, 1967). In their influential paper, Wootton and Allen (1983) delineated parallel similarities between schizophrenic breakdown and religious conversion by using the schizophrenia model of Docherty et al. (1978) and the religious conversion scheme of Christensen (1963). From an unconscious conflict - associated with the feeling of anxiety, guilt, depression, and confusion - to the experience of submission and impasse, religious conversion and psychotic breakdown are similar (Wootton & Allen, 1983). However, religious conversion is resolved by the reintegration of ego functions (Christensen, 1963), whereas psychosis ends up with disinhibition, disorganization, and distorted ontology (Docherty, Van Kammen, Siris, & Marder, 1978).

Despite this powerful model, comprehensive reviews of research from the subsequent decades failed to reveal a straightforward relationship between religious conversion and psychotic disorders (Koenig, King, & Carson, 2001, 2012; Wilson, 1998).

Before the publication of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994), there was a strong tendency to interpret spiritual and religious phenomena as mere signs and symptoms of psychopathology (Lukoff, 1998). The intellectual and political battle among the great pioneers did not facilitate resolution of the long-term problem (Frankl, 1959; Freud, 1961; Hall, 1917; James, 1902; Jung, 1938). In DSM-5, the section “Problems related to other psychosocial, personal and environmental circumstances” includes spiritual crisis, which is not a mental disorder *per se*, although it may have a significant impact on the outcome of existing disorders (American Psychiatric Association, 2013): “V 62.89 (Z 65.8). This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution.” (American Psychiatric Association, 2013).

When the religious and spiritual problem is accompanied by heightened and intrusive imagery, visions and hallucinations, odd thoughts and behavior, or deeply depressed mood, individuals easily receive the diagnosis of serious mental disorders. If the cultural background and the autobiographical history of the individual are not carefully taken into consideration, glossolalia, verbal messages and other salient signs from the divine, feelings of being possessed by devil forces, contact with spirits, and out-of-body experiences can easily be labeled as psychotic symptoms. There is no doubt that in the clinical practice

religious and spiritual problems raise difficulties for differential diagnosis (Allmon, 2013; Chandler, 2012; Peteet, Ju, & Narrow, 2011; Prusak, 2016). As suggested by Pargament and Lomax (2013), unhealthy spirituality is always incoherent and poorly integrated: “it is ill-equipped to deal with the full range of internal and external life demands because it lacks comprehensiveness, depth, flexibility, dynamism, balance, and coherence.” (Pargament & Lomax, 2013) These problems may be secondary to a psychiatric disorder (e.g., religious hallucinations and delusions in a schizophrenia patient), or, on the other hand, religious problems may be the proximal cause of psychological distress. Complex, mixed cases also occur when religious problems may be both a cause and a consequence of mental disorders (Pargament & Lomax, 2013; Penzner, Kelly, & Sacks, 2010).

Mystical experiences and spiritual emergency, which may manifest themselves as religious and spiritual problems according to the DSM-system, may ultimately serve personal and transcendent growth, development, and empowerment. It may be detrimental to categorize them as purely pathological and psychological phenomena (Corbett, 1996; C. Grof & Grof, 1990; S. Grof & Grof, 1989; Jonte-Pace & Parsons, 2001; Nelson, 1994). Thus, in addition to the detection of anomalous and unusual experiences, the clinician should take into consideration social-personal context, meaning-making functions, coherence of thinking, self-reflection and insight, and the circumstances of onset (e.g., major life events or identity crisis) (Vieten, Scammell, & Siegel, 2015).

The classification and detailed evaluation of so-called anomalous experiences and cognitive deficits may also provide valuable information for the differentiation of religious/spiritual problems and frank psychosis. However, in this respect, the literature needs major improvements, and more data are clearly warranted. For instance, let us consider the case of individuals referred to special psychiatric services with an initial diagnosis of psychotic episode. Some of them will show frank

psychosis (e.g., schizophrenia-spectrum disorders or mood disorders with psychotic features), whereas others will meet the DSM-criteria of religious/spiritual problems without a major mental illness. Is there any similarity or difference between these groups in the subjective experience of perception, thinking, and feeling centered around the conscious representation of the self (McCarthy-Jones, Waegeli, & Watkins, 2013; Mishara, Lysaker, & Schwartz, 2014; Sass & Parnas, 2003)? Is it true that some psychosis-like features and cognitive dysfunctions can be detected in people with hard religious and spiritual problems?

III. MAPPING ANOMALOUS INNER EXPERIENCES: THE BASIC SYMPTOM APPROACH

In 1962 Huber developed the Heidelberg Checklist, which delineated common subjective inner experiences, complaints, and deficiencies of schizophrenia patients (Huber, Gross, & Schüttler, 1979). Later, the checklist was extended and improved in the Bonn Scale for the Assessment of Basic Symptoms (BSABS) (Gross, Huber, Klosterkötter, & Linz, 2008). These basic symptoms, which are present in the prodromal (initial) and residual (post-psychotic) form of schizophrenia, may constitute the basis of frank psychotic symptoms emerging as a reaction to and compensation of basic symptoms (Gross et al., 2008). Subjective experiences reported by schizophrenia patients comprise a broad spectrum of more or less specific phenomena, including perception, thinking, mood, social relationships, and self-representation (Klosterkötter, Ebel, Schultze-Lutter, & Steinmeyer, 1996; Klosterkötter et al., 2001). The main hypothesis of the present study was that basic symptoms could be explored not only in early psychosis but also in individuals with spiritual and religious problems. However, in this latter group, basic symptoms will not turn into frank psychosis.

Another issue is the presence or absence of cognitive and neuropsychological deficits,

primarily affecting executive functions, attention, and memory. It is extensively documented that patients even in the early stage of psychosis display significant and broad cognitive deficits that can be detected by neuropsychological tests (Aas et al., 2014; Bora & Murray, 2014; Keefe & Harvey, 2012).

In BSABS, we use a semi-structured interview (Gross et al., 2008). The following dimensions were evaluated: 1. *diminished affectivity* (4 items, e.g., diminished initiative and dynamism, anhedonia, diminished feelings of others, diminished need for interpersonal relations); 2. *disturbed contact* (13 items, e.g., lack of ability for interpersonal contact, vulnerability to interpersonal contact, inability to tolerate crowd, increased impressionability by others' behavior, increased impressionability by others' suffering); 3. *perplexity* (11 items, e.g., ambivalence, inability to discriminate between own feelings, hyperreflectivity/loss of naturalness, disturbed receptive language, inability to re-visualize, inability to understand symbols, inability to grasp significance of perception, heightened perception, captivation of attention by perceptual detail, derealization: strangeness and intrusive perception); 4. *cognitive disorder* (6 items, e.g., thought interference, thought pressure, thought block, successive thought block and thought interference, disorder of expressive language, diminished thought initiative and goal-directedness of thinking); 5. *self-disorder* (4 items, e.g., psychic depersonalization, somatic depersonalization, "mirror" phenomenon, e.g. impression of a change in one's mirror image, experience of discontinuity in own action); 6. *cenesthesias* (4 items, e.g., electrical bodily sensations, sensation of movement, pressure or pulling on the body or on the body surface, sensations of lightness, heaviness, levitation, falling, constriction, dilatation, shrinking or expansion of the body); 7. *perceptual disorder* (13 items, e.g., unclear seeing, partial sight, photopsia, micro-macropsia, meto-chromopsia, changes in perception of others' faces or figures, skewed sight/disturbed perspective, disturbed

sense of distance, disturbed rectilinearity, dysmegalopsia, abnormal persistence of visual irritation). Each item was coded as 0 (the subjective experience indicated by the item is not present) and 1 (the subjective experience specified by the item is present). Higher scores mean more pronounced anomalous subjective experiences.

A more careful examination reveals substantial differences between BSABS scores in psychosis and religious conversion: although subjective experiences related to self-disorder and perplexity are present in people with spiritual crisis at a similar level to that seen in psychosis, diminished affectivity, disturbed contact, cognitive disorder (subjective and neuropsychologically detectable), cenesthesia, and perceptual disorder are much less pronounced. Diminished affectivity and cognitive dysfunctions discriminated patients with psychosis from individuals with spiritual and religious problems. Although in today's typical medical environment spiritual crises may easily be labelled as pathological, a wealth of studies suggest that even profound and turbulent transformations may have a positive impact on personal development, creativity, finding of meaning, empowerment, and openness to new experiences (Clark, 2010; C. Grof & Grof, 1990; S. Grof & Grof, 1989; Nelson, 1994; Vieten et al., 2015). Nevertheless, one should not neglect the potential negative consequences of spiritual transformation, the disappointment and pain of deconversion, and the necessity of special psychological care for vulnerable individuals in spiritual crisis (Exline & Rose, 2005).

Individuals with religious conversion experienced deep subjective changes in their self, including depersonalization, ambivalence, discontinuity of actions and feelings, hyperreflectivity/loss of naturalness, and heightened/intrusive perception. These findings are consistent with the view that religious conversion is often associated with profound and broad changes in core personal identity and with the reconstruction of meaning-making systems (beliefs, attitudes, values, and purposes) (Hill, 2002; Hood, Hill, &

Spilka, 2009; Jung, 1938; Paloutzian, 2005, 2014). Sometimes these changes are not without spiritual and religious struggles accompanied by distress, confusion, anxiety, desperation, and depression, i.e. the “dark night of the soul” (Lofland & Stark, 1965; Pargament et al., 2004; Rambo, 1995; Snow & Machalek, 1984). A quest for identity and finding who one really ought to be are among the main antecedents and driving forces of religious conversion (Beit-Hallahmi & Argyle, 1997; Hefner, 1993; Maruna, Wilson, & Curran, 2006). The success of the journey is dominated by positive emotions, empowerment, meaning, and self-worth (Hill, 2002).

By using the basic symptom approach, we do not intend to pathologize religious conversion and spiritual transformation. In our view, subjective experiences of sensing, thinking, and feeling are sometimes out of their default range, leading to various extraordinary psychological phenomena, but it does not mean that an individual experiencing some of them suffers from a psychiatric disorder. There are numerous examples when religious conversion is smooth, gradual, rational, and culturally embedded (Silverstein, 1988). By using a Bible-based analysis including various sections of the Acts and the Gospel of Mark, Peace (1999) demonstrated differences in the conversion experiences of Paul (Saul of Tarsus) and the Twelve Disciples delineating the distinct features and scriptural representations of sudden and gradual changes.

Ethnographic interviews from “born again” Evangelical Christians revealed that long-term internal disharmony and dissatisfaction were more frequent antecedents of conversion than actual life crises, and, as a consequence of transformation, the representation of the self was fundamentally changed: “God centred rather than self centred, serving God’s purpose, giving control to God, dying to self, lesser self preoccupation and self forgiveness” (Stout & Dein, 2013). In these cases, the conversion was primarily intellectual driven by the teachings of the church (Stout & Dein, 2013), but self-transformation was an

essential factor as described by the first psychological models of religious conversion (Starbuck, 1879). Luhrmann (2012) interviewed members of the Vineyard, an Evangelical church with hundreds of congregations across the United States. These interviews clearly showed that intensely practiced prayer in people with Christian faith and spiritual sensitivity could be associated with experiences of signs and wonders from the supernatural. Even unusual perceptions may possess cultural relevance and meaning by absorption (inner imagery) and by inner sense cultivation practices, which are qualitatively different from psychotic symptoms (Luhrmann, 2017).

IV. SPIRITUAL EXPERIENCES IN CONVERSION AND PSYCHOSIS

Classic analyses of autobiographical accounts from patients with schizophrenia and persons with mystic experiences indicated increased sense of noesis, inward attention to the self, enhanced perception, and feelings of union with supernatural and divine powers. In contrast, auditory hallucinations and thought disorder, which are key features of schizophrenia, were not characteristic for mystic experiences (Brett, 2002; Buckley, 1981). It is consistent with our results indicating no evidence for disturbed thought and cognition in religious conversion. The term “mystic delirium” is used to illustrate an altered state of consciousness, which is not the same as seen in schizophrenia (Schmidt, David, & Bouquet, 1972). In “mystical psychosis”, there is a deautomatization of habitual and default stimulus selecting and organizing mechanisms as a consequence of major life events, psychoactive substance use, or repetitive environmental stimuli. This deautomatization may lead to the emergence of novel insights and associations building into the belief and value system of the individual (Deikman, 1971). Mystic experiences are embedded in altered states of consciousness, but individuals can control their inner world and can make distinctions between the real and the imaginary, a sharp contrast in relation to

psychosis (Campbell, 1972). According to Bhargav et al. (2015), both spiritual maturation and psychosis are characterized by an altered representation of the self. In psychosis, there is a disruption of self-related processes (e.g., lack of sense of self, feeling of lack of existence, and social withdrawal), whereas in spiritual transformations a gradual reduction of the self-centered attitude can be observed, merging into a universal consciousness (Bhargav, Jagannathan, Raghuram, Srinivasan, & Gangadhar, 2015; Iyengar, Evans, & Abrams, 2005; Stanghellini & Fusar-Poli, 2012). Although participants with religious and spiritual problems exhibited self-disorder, perplexity, and some perceptual anomalies in the present study, their spared cognitive capacity might have prevented them from the loss of reality testing.

However, large-scale population-based studies indicated positive correlations between mystic/spiritual/religious phenomena and psychosis-like experiences, questioning the feasibility of differentiation between these conditions (Goretzki, 2007; Lewis-Fernandez et al., 2009). Siddle et al. (2002) reported that that patients who experienced past changes in religiosity and doctrinal orthodoxy were almost ten times more likely to develop religious delusions, which may indicate a role of conversion in the emergence of psychosis with religious content. However, self-reported religiosity and Christianity exhibited only a small potential effect on religious psychopathology (Siddle, Haddock, Tarrier, & Faragher, 2002). Similar findings have been published in other studies (Kéri & Kelemen, 2016; Mohr, Gillieron, Borrás, Brandt, & Huguelet, 2007; Rudaleviciene, Stompe, Narbekovas, Raskauskiene, & Bunevicius, 2008). Religious faith is sometimes related to delusions during the acute phase of psychosis, but, in other cases, it is linked to existential problems and may have a positive impact on the restoration of self-representation (Miller & McCormack, 2006).

Some authors claim that spiritual and religious phenomena (e.g., communication with God via

thought insertion and verbal messages) are entirely different from psychotic symptoms in phenomenology, quality, valence, and outcome (Dein & Cook, 2015). However, the literature is not conclusive (Cook, 2015; Koenig et al., 2012). With the appearance of alternative spiritual movements, multicultural influences, eclectic New Age mysticism, and spiritual-but-not-religious attitudes, religious beliefs and delusions became difficult to define. Classic themes of sin, resurrection, reincarnation, messianism, devil, and angels are easy to classify in terms of traditional religions, but the phenomena of spirit possession, communication with the dead, superstition, future telling, astrology, and folk metaphysics are much more problematic (Cook, 2015).

V. RELIGIOUS THOUGHT: DOCTRINAL FOCUS IN CONVERSION

When people are asked to select Bible passages best describe their inner experiences, individuals experiencing religious conversion and psychosis give fundamentally different responses. In conversion responses are much more consistent. The doctrinal focus is laid on the destruction of the old self (Ephesians 4:22-24), new life and resurrection by baptism into the death of Jesus Christ (Romans 6:3-6), death to self (Colossians 3:1-3), and being born again to see the Kingdom of God (John 3:3).

Another main focus was the active work of the Holy Spirit, especially in relation to Pentecostal/Charismatic conversion: sin against the Son of Man and the Holy Spirit (Matthew 12:32), praising the Father when filled by the joy of the Holy Spirit (Luke 10:21), teachings of the Advocate, the Holy Spirit (John 14:26), repenting and being baptized in the name of Jesus Christ for the forgiveness of sins and receiving the gifts of the Holy Spirit (Acts 2:38), living with the gifts of the Holy Spirit: wisdom, knowledge, faith, healing, prophecy, and speaking of tongues (Romans 12:6-9; 1 Corinthians 12:7-10; Ephesians 4:7-14).

Interestingly, the topics of being born again, dying to self, saving from sin, and God-centered rather than self-centered view were also prevalent in our participants who experienced a more turbulent and emotion-laden conversion as compared to the individuals described by Stout and Dein (2013). However, the intellectual-doctrinal aspects were not absent in the case of our volunteers. The key Bible passages selected by our participants indicated that the main doctrinal focus was laid on the destruction and death of the old self, new life and resurrection by baptism into the death of Jesus Christ, and being born again for the Kingdom of God. The transformative work of the Holy Spirit was also dominant with a special reference to repenting and being baptized in the name of Jesus Christ for the forgiveness of sins and receiving the gifts of the Holy Spirit such as faith, wisdom, healing, prophecy, and speaking of tongues. The remarkably high percentage of individuals selecting the same Bible passages can be explained by the fact that they attended the same or similar religious communities sharing a common doctrinal focus and teaching.

There are several shortcomings and methodological limitations of the studies investigating the connection between conversion and psychosis. First, studies are often confined to the quantitative measurements of subjective experiences, and key themes and personal motives were not systematically identified. Religious conversion is much more complex than a pure solipsistic and intrapsychic process detached from the socio-cultural context (Jindra, 2016). In the theology of Barth (1955/2010) and Bonhoeffer (1937/1966), the call to discipleship is a kind of awakening to conversion, based on the work of Jesus Christ, a divine revelation and mystery beyond and outside psychological phenomena. Second, the sample sizes are small, and the individuals investigated are rarely representative for religious conversions in general.

In conclusion, the results reported in the literature support for the role of self-

transformation in religious conversion, which might phenomenologically resemble psychotic perplexity and self-disorder. However, these anomalous subjective experiences must be interpreted against the background of sociocultural and personal factors, as well as other dimensions of experiences to avoid unnecessary and harmful medicalization and stigmatization.

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