Brazilian Journal of Psychiatry
bjp
Revista Brasileira de Psiquiatria

Braz J Psychiatry. 2023 Nov-Dec;45(6):506-517
doi:10.47626/1516-4446-2023-3056
Brazilian Psychiatric Association

SPECIAL ARTICLE

Brazilian Psychiatric Association guidelines on the integration of spirituality into mental health clinical practice: Part 1. Spiritual history and differential diagnosis

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Objectives: To present evidence-based guidelines for clinical practice regarding religiosity and spirituality in mental health care in Brazil.
Methods: A systematic review was conducted to identify potentially eligible articles indexed in the PubMed, PsycINFO, SciELO, LILACS, and Cochrane databases. A summary of recommendations and their levels of evidence was produced in accordance with Oxford Centre for Evidence-Based Medicine guidelines.
Results: The systematic review identified 6,609 articles, 41 of which satisfied all inclusion criteria. Taking a spiritual history was found to be an essential part of a compassionate and culturally sensitive approach to care. It represents a way of obtaining relevant information about the patient's religiosity/spirituality, potential conflicts that could impact treatment adherence, and improve patient satisfaction. Consistent evidence shows that reported perceptual experiences are unreliable for differentiating between anomalous experiences and psychopathology. Negative symptoms, cognitive and behavioral disorganization, and functional impairment are more helpful for distinguishing pathological and non-pathological anomalous experiences.
Conclusion: Considering the importance of religiosity/spirituality for many patients, a spiritual history should be routinely included in mental health care. Anomalous experiences are highly prevalent, requiring a sensitive and evidence-based approach to differential diagnosis.

Keywords: Religion; spirituality; mental health; spiritual history; differential diagnosis; psychiatry

Introduction

Religion/spirituality (R/S) is one of the most important aspects of life across different cultures worldwide.[1] According to global surveys, around 84% of the world's population claims to have some religious affiliation and this percentage is increasing.[2] According to a nationally representative survey in Brazil, 83.4% of adults and 73.9% of adolescents reported that religion was very important in their lives.[3] Religiosity and spirituality are multidimensional constructs lacking a single or consensual definition. More inclusive definitions of spirituality have been proposed, including experiences of well-being, meaning, peace, or connectedness with nature, self, and others, but they are open to criticism for being unspecific and incapable of distinguishing spirituality from well-being and other human experiences.[4] However, according to one commonly agreed definition, spirituality "is the relationship or contact with a 'transcendent' realm of reality that is considered 'sacred,' the ultimate truth or reality," whereas religion is "the institutional or communal aspect of spirituality, a shared set of beliefs, experiences and practices related to the transcendent and the sacred."[5] The combined term R/S is often used as a broad-brush reference to both concepts.[6] Increasing high-quality evidence has demonstrated the impact of R/S on different mental health conditions.[7] Generally, engagement with R/S is inversely related to mental illness and is

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Submitted Jan 26 2023, accepted Jun 25 2023.

How to cite this article: Mosqueiro BP, Costa MA, Caribé AC, Oliveira e Oliveira FHA, Pizutti L, Zimpel RR, et al. Brazilian Psychiatric Association guidelines on the integration of spirituality into mental health clinical practice: Part 1. Spiritual history and differential diagnosis. Braz J Psychiatry. 2023;45:506-517. http://doi.org/10.47626/1516-4446-2023-3056

positively associated with psychological well-being and quality of life.[1] Prospective high-quality studies have confirmed the predominantly positive effect of R/S across different psychiatric conditions, including depressive disorders[8] and bipolar disorders,[9] and even greater protective effects regarding substance use disorders[10] and suicide risk.[11,12] However, since specific ways to interpret or experience R/S, including the use of negative religious coping strategies, could be associated with worse mental health outcomes, clinicians should be aware of these potential negative effects in clinical practice.[13,14]

Many people turn to R/S beliefs, practices, and organizations for support when faced with life's adversities, illnesses, or mental health issues.[15] R/S beliefs are also acknowledged as an important factor in patient decision-making, as well as adherence to and satisfaction with treatment.[16] R/S issues also represent a key aspect of differential diagnosis in mental health, as illustrated by the overlap of certain R/S experiences with psychotic symptoms.[17]

Indeed, most patients would like to talk about their R/S in health care settings but, surprisingly, most have never been asked.[18] In this regard, various international associations have produced recommendations on the importance of integrating R/S into mental health care, including the American Psychiatric Association, the Royal College of Psychiatrists, and the German Psychiatric Association.[19] The World Psychiatric Association published a Position Statement on Spirituality and Religion in Psychiatry that recommended integrating R/S into mental health research, training, and clinical practice.[20]

Despite the available evidence and recommendations, there are few evidence-based guidelines on how to incorporate R/S into mental health care. Based on a comprehensive, systematic review of the literature, the present study provides a summary of practical recommendations based on the best available evidence and an ethically informed approach to R/S regarding three main research questions: 1) How to take a religious/spiritual history (SH)? 2) What evidence should be considered in the differential diagnosis between psychiatric disorders and religious or spiritual experiences? 3) How to integrate R/S into psychiatric treatment? This paper reports the results for the first two questions.

Methods

A systematic review of the evidence was conducted by a group of nine Brazilian psychiatrists with expertise in R/S, psychiatric research, and clinical practice who are members of the Section on Spirituality and Mental Health Research of the Brazilian Psychiatric Association.

Structured, clinical questions were defined to clarify the search strategy and summarize the findings according to the Population, Intervention, Comparator and Outcomes model, as recommended by the Brazilian Medical Association Guidelines Project. The above-mentioned research questions were used to address three most important issues regarding R/S and mental health in clinical practice.

As a first step, the search terms for each research question were comprehensively discussed by three researchers until consensus was reached. An initial comprehensive search strategy identified potentially eligible articles in English or Portuguese indexed in the PubMed, PsycINFO, SciELO, LILACS, and Cochrane databases from inception until July 2020.

The results for each research question were then evaluated independently by two authors to select potentially eligible articles through title and abstract assessment. Any questions about inclusion were discussed with a third senior researcher. All selected articles were then read in full and, in a second phase, comprehensively analyzed by the authors of each subgroup. A final qualitative summary of findings was reported for each research question. Oxford Centre for Evidence-Based Medicine criteria were used to determine the level of evidence for all clinical recommendations.[21]

The following inclusion criteria were used for the first research question: observational studies, clinical trials, systematic reviews, or meta-analyses including evidence about SH-taking in mental health practice. The following search terms were combined according to the respective databases: ''spirit*,'' ''religio*,'' ''clinical practice,'' ''interview,'' ''history,'' ''anamnesis,'' ''psychol*,'' ''psychiatr*'' and ''mental.'' In view of the limited number of studies identified in the first phase of the strategy, an additional search of the PubMed database was performed to include systematic reviews, meta-analyses, and randomized clinical trials from different health care and medical settings, and removing the ''psychiatr*'' and ''mental'' search terms.

The following inclusion criteria were used for the second research question: case series, cross-sectional, prospective, or case-control studies, systematic reviews, or meta-analyses including evidence about differential diagnosis between R/S experiences and psychopathology. The following search terms were combined according to the respective databases: ''differential diagnosis,'' ''distinct*,'' ''differentiat*,'' ''anomalous,'' ''religio*,'' ''mystic*,'' ''paranormal,'' ''possession,'' ''trance,'' ''extrasensory,'' ''spirit*, ''trance,'' ''mediumship,'' ''mediumistic,'' ''psychotic,'' ''psychosis,'' ''mental disorder,'' ''mental illness,'' ''psychiatr*,'' and ''dissocia*.'' The terms were restricted to titles or abstracts in the PubMed and PsycINFO databases. Narrative reviews encompassing relevant background information and critical appraisals of the literature by expert researchers on differential diagnosis between spiritual experiences and psychopathology were included. Information from narrative reviews required an evidence level of 5 according to Oxford Centre for Evidence-Based Medicine criteria.

We included additional relevant publications from the references of selected papers or others known by the authors. The search strategies for research questions 1 and 2 are presented in Preferred Reporting Items for Systematic reviews and Meta-Analyses flowcharts (Figures S1 and S2, respectively, available as online-only supplementary material).

A detailed risk of bias assessment and critical appraisal of individual studies was performed using validated assessment tools to reinforce confidence in the evidence and understand potential problems that could distort or

bias the results (Tables S1, S2, S3, and S4, available as online-only supplementary material). The University of Bristol Risk of Bias in Systematic Reviews tool was used to assess the methodological quality of systematic reviews,[22] while Cochrane risk-of-bias tools were used for randomized trials (RoB 2) and non-controlled trials (ROBIS-E),[23] and the Joanna Briggs Institute critical appraisal checklist for analytical cross-sectional studies.[24]

Results

The results for each research question are presented separately, comprehensively reviewed and summarized according to the scientific literature.

How to take a religious or SH?

We identified 5,439 articles from all databases, of which 5013 were screened after removing duplicates. Based on title and abstract assessment, 43 were considered relevant for full-text reading. Following a comprehensive full-text reading, 12 were included in this review (eight identified in the database search and four identified through other sources) (Figure S1), including five systematic reviews, four randomized clinical trials, two non-controlled trials, and one prospective, observational study. We evaluated and discussed these studies under four headings: the importance of taking a SH in mental health practice; barriers to addressing patient spirituality; ethical and clinical principles for taking a SH; and training in taking a SH.

The importance of taking a spiritual history in mental health practice

SH assessment provides a framework for understanding relevant and distinctive aspects of the patient's experiences, perceptions, and needs, while helping comprehend symptoms potentially associated with mental health.[25]

There are many reasons to take a SH in mental health care: i) it is an aspect of person-centered, compassionate, and culturally sensitive care[18,26]; ii) it appears to foster a positive relationship between health professionals and patients, enhancing treatment satisfaction[27,28]; iii) it is an important way to find out about the patient's R/S culture, beliefs, and behaviors, identifying beliefs that provide meaning and purpose in life for many patients[6,26]; iv) it can help find personal and community R/S resources useful for coping with suffering and distress[6,15]; v) it can identify R/S beliefs or struggles that might affect mental health, decision-making, and important issues in psychiatric treatment[14,29]; vi) it can help in the differential diagnosis between R/S experiences and psychopathology[30]; and vii) it can identify individuals who might benefit from pastoral care, counseling, or specialized spiritual care[6,26] (Table S5, available as online-only supplementary material).

Evidence from different populations suggests that taking a SH has positive effects (Table S5). For instance, a randomized controlled trial at the University Hospital of Geneva (n=84) investigated the impact of taking a SH during regular psychiatric appointments for outpatients with schizophrenia or other non-affective psychoses, finding potential clinical usefulness in 67% of patients. Patients welcomed the assessment, with more than one-quarter being very open to discussing R/S issues with their psychiatrists. However, after the three month follow-up period, no differences in care satisfaction or medication adherence were observed between patients who had and had not been asked about their SH. Nevertheless, those who were asked about SH had better attendance at appointments during follow-up.[29]

Another study with 118 cancer patients from multicenter oncology clinics in the United States found that taking a brief SH (5-7 minutes) was perceived as comfortable and useful by the majority of patients and physicians. After 3 weeks, patients from whom a SH had been obtained reported fewer depressive symptoms, better quality of life, and a sense of interpersonal caring from their physicians than the control group.[27]

A study of 3,141 general internal medicine inpatients at the University of Chicago Medical Center found that 41% were open to discussing R/S issues while hospitalized, although only half reported having had such discussions. Notably, those who had discussed R/S concerns were much more likely to report the highest level of patient satisfaction.[28]

However, another randomized clinical trial found that a specific protocol for SH-taking among palliative home care patients had no significant impact on spiritual well-being, quality of life, pain, or patient-provider trust.[31] The limited sample size (n=49), and the difficulty in ascertaining whether spiritual conversations occurred in the control group were important limitations to accurate assessment of the intervention's effectiveness.[31]

Overall, the evidence suggests that taking a SH has a predominantly positive effect on clinical practice, not only introducing relevant clinical information, but also potentially improving doctor-patient relationships and treatment satisfaction. Due to the limited number of studies, it is not clear how taking a SH could be made more feasible and effective in patients from different cultures and in different clinical settings.

Barriers to addressing patient spirituality

Although many patients wish to discuss R/S in their consultations, many clinicians encounter barriers to addressing spiritual needs in clinical practice (Box 1). A survey of 484 Brazilian psychiatrists revealed that most (76.8%) consider it very, or reasonably, important to integrate patient R/S into clinical practice, although more than half (55.5%) do not usually inquire about patient R/S. The main reported barriers to addressing R/S in clinical practice were: i) concerns about overstepping ethical boundaries (30.2%), ii) a lack of training in R/S (22.3%), and iii) a lack of time (16.3%).[32]

A systematic review of more than 20,000 medical reports found that R/S was rarely addressed in health care consultations.[33] SH-taking was reported by 16-34% of physicians (median 32%), with a higher frequency

Box 1 Main perceived barriers and recommendations regarding spiritual history

Barriers	Recommendations
Ethical concerns	Most patients would like to talk about R/S with mental health professionals. A respectful, open, culturally sensitive, non-proselytizing, and patient-centered approach is recommended and supported by research and international guidelines.
Lack of time	Brief SH assessments (5-minute interviews) have shown benefits in clinical practice in time-limited contexts and can provide a reliable initial perspective of the patient's R/S concerns and interests.
Lack of training	Evidence confirms the efficacy and viability of SH training to provide the knowledge and skills needed to take a SH. Structured questionnaires and interviews are helpful resources for mental health interviews.
Concerns about causing distress or exacerbating the psychopathology	Most patients are comfortable with and wish to talk to mental health professionals about R/S issues. Taking a SH has been associated with greater treatment satisfaction with better doctor-patient relationships.
Extensive knowledge needed about religion and diverse cultural backgrounds	No prior extensive knowledge is required for primary assessment of R/S in mental health care. Creating an open environment and encouraging patients to share R/S concerns in a respectful, open, and considerate interview are achievable goals.
Concerns about negative mental health outcomes resulting from R/S beliefs or practices	The literature confirms that R/S measures in mental health have a predominantly positive outcome. For patients with R/S struggles or who are suffering, SH-taking enables clinicians to understand and helps patients find resources to deal with perceived negative effects.

R/S = religiosity/spirituality; SH = spiritual history.

among psychiatrists (48-78%, median: 50%). The most commonly reported obstacles included a lack of time, insufficient knowledge or training, concerns about ethical boundaries, cultural differences between patients and doctors, worries about colleague disapproval and, for a minority of doctors, the belief that R/S could have a negative effect on patient outcomes. Although several instruments were mentioned, there was little evidence that standardized tools were widely used. Those who regularly took a SH preferred their own standard questions phrased in their own words. The most frequently reported topics of discussion included encouraging patients in their own R/S beliefs, inquiring how faith influenced health care decisions, and concerns about death and dying. Discussion of R/S was more likely in contexts of family crisis, medical emergencies, or end-of-life. Spiritual discussions occurred more frequently with psychiatrists, palliative care, and primary care physicians than with other medical specialties. Doctors with stronger R/S beliefs were more likely to address R/S in a medical consultation, but prior training in discussing R/S in clinical settings was the strongest predictor of spiritual care discussions.[33]

Ethical and clinical principles for taking a spiritual history

A key issue in clinical practice is how to proceed when taking a SH in mental health care. A few recommendations should be observed when assessing a patient's R/S: SHs should be taken in a patient-centered way that involves ethical commitment without proselytizing or prescribing religious or anti-religious perspectives[18]; the approach must be respectful to the patient's faith and culture, and the process should be focused on the patient's beliefs and needs. It is of fundamental importance that spiritual assessment should not be confused with pastoral counseling or proselytism in favor of or against any religious or spiritual worldviews. It is recommended that clinicians personally reflect on their own personal beliefs and SH in view of counter-transferential concerns, while remaining aware that they may influence the patients' beliefs and perceptions.[25]

The patient's SH could be explored using open-ended questions based on the topics presented in Box 2.[27] Along with obtaining relevant information, the essential purpose of the SH is to create an open environment and help patients feel comfortable, valued, and respected when discussing their R/S issues (Box 3).[25]

SH-taking should be actively and routinely incorporated into clinical practice. Many patients might feel uncomfortable or uncertain about spontaneously introducing R/S topics in clinical encounters. A systematic review found that patients were more likely to spontaneously raise R/S issues only when they disagree with medical recommendations.[33] A randomized clinical trial with palliative care patients showed that patients who were asked directly about their R/S concerns, especially during the first consultation, were much more likely to discuss spirituality than those who were not.[34]

Contrary to certain concerns about SH, obtaining a SH does not require clinicians to have prior, extensive religious knowledge. An open, respectful, and considerate readiness to listen and understand is a viable way to start conversations about R/S with patients. There is evidence that even a brief R/S screening and assessment is quite helpful and should be incorporated as an important clinical aspect of patient interviews.[35]

Box 2 Questions for assessing spiritual history in mental health

Routine questions for a brief SH

1) Are you a spiritual or religious person? or, Do you have a religious or spiritual beliefs? Tell me more about that.
2) To what extent is religion or spirituality important in your life?
3) Are you part of a religious or spiritual community?
4) Are religion or spirituality important sources of strength for you when dealing with stress or life's difficulties? or, What are your sources of strength when dealing with life's difficulties or stress? Do you have any beliefs or practices that help you cope?[†‡]

Questions for exploring specific R/S topics when necessary

Beliefs concerning meaning and life
- What gives you meaning or purpose?[†]
- What are your beliefs concerning death?[†]

Private practice
- Do you have any personal or private religious practices, such as meditating, praying, playing or singing sacred music, or reading the scriptures? Are they helpful?[†‡]

Organized practice
- Do you have any community religious practices, such as belonging to a faith tradition, participating in services, rituals, worship, pilgrimages, retreats, helping other people, engaging in a study group? Are they helpful?[†‡]
- If you do not, would you be interested in engaging in a religious or spiritual community?[‡]

Community relationship
- Do you receive support from or have difficulties with your faith community?[†]

Spiritual experiences
- Have you ever had any spiritual experiences? What meaning did you attribute to these experiences?[†]

Relationship with God/the transcendent, R/S struggles, and coping
- Do you believe in God or some transcendent or higher power?[†]
- If so, what is God like?[†]
- Do your R/S beliefs and practices support your well-being and mental health, or do they make it more difficult to deal with some part of your treatment?[†‡]
- Do you find yourself struggling with concerns about God or your spiritual beliefs?[†]
- Do you feel loved, accepted, a sense of belonging, forgiven, closer to God, or rejected, guilty, ashamed, afraid, and more distant from God?[†‡]
- Do you have any R/S needs in your life that are not being met?[‡]

Integrating R/S into treatment
- Do you believe that your R/S practices and beliefs can support your recovery? If so, how?[†]
- Do you have R/S questions that you want to explore? Is there someone who cares for you with whom you can talk about your spiritual life?[†]
- If there is something that might help you but you cannot access it, how can I help you get access? It is important for you to know that:
  - You can talk to your faith leaders and involve them in your treatment.[†]
  - Several current treatments consider R/S issues, such as 12-step programs for alcohol and substance misuse, mindfulness-based interventions for dealing with stress, anxiety and depression, and spiritually and religiously integrated psychotherapy.[†]

R/S = religiosity/spirituality; SH = spiritual history.
[†] Question based on Royal College of Psychiatrists Assessment.
[‡] Question based on Spiritual Assessment Interview.

Box 3 Summary of recommendations for taking a spiritual history

1. The SH should be patient-centered, neither prescriptive nor proselytizing, and should be culturally sensitive to patient beliefs, practices, and worldviews.
2. In addition to obtaining important R/S information, the main objective is to create an open and respectful environment where patients can share beliefs, concerns, and perspectives about R/S.
3. R/S assessments should be routinely included in mental health interviews.
4. The SH interview should use patient-centered, open-ended questions.
5. Initial R/S inquiries can begin by asking about the patient's social, community, and personal interests.
6. The inquiry should be flexible and adapted to the patient's responses, observing verbal and non-verbal clues.
7. Brief interviews are viable and provide useful information for screening, time-limited, and initial assessments.

R/S = religiosity/spirituality; SH = spiritual history.

Two systematic reviews have summarized evidence concerning the available instruments for taking a SH and assessing spiritual suffering.[35,36] Most of the 25 instruments were developed for general use in clinical practice. An instrument known as Faith, Importance/Influence, Community, and Action/Address in care (FICA) obtained the highest scores for clinical utility and applicability and is among the most commonly used instruments. Only two such instruments have been developed specifically for mental health: the Royal College of Psychiatrists Assessment and the Spiritual Assessment Interview. Table 1 provides a set of questions for conducting a brief initial SH assessment, as well as for conducting a more detailed exploration of specific R/S topics when necessary for a particular patient. The initial questions may be routinely asked when taking a patient's social history.

Table 1 Criteria and level of evidence for differentiating clinical and non-clinical individuals with anomalous experiences

Criteria	Studies	Specifiers	Recommendation	Level of evidence	Comments
1	Jackson & Fulford[39‡]	Characteristics of the experience	Assess the duration of loss of contact with reality.	5	The clinical group tends to lose contact with reality for longer periods of time than the non-clinical group.
2	Peters et al.[40] Peters et al.[41] Bronn & McIlwain[42†] Escolà-Gascón[43†] Humpston et al.[44†] Jackson & Fulford[39†] Moreira-Almeida et al.[45] Unterrassner et al.[46†] Vencio et al.[47] Brett et al.[48] Brett et al.[49]	Characteristics of the experience	Most content and form of anomalous experiences and paranormal beliefs do not differ between clinical and non-clinical groups.	2	Extrasensory perception, dissociative experiences, hallucinations, paranormal beliefs, unusual perceptions, thought insertion, mind reading, and feelings of being controlled do not differ between clinical and non-clinical groups.
3	Peters et al.[40]	Characteristics of the experience	The intensity of the phenomenon did not differ between clinical and non-clinical groups.	3	The intensity of the phenomenon/number of anomalous experiences did not differ between clinical and non-clinical groups.
4	Peters et al.[41]	Characteristics of the experience	Assess lifetime history of anomalous experiences.	3	Age of onset is earlier and time lived with anomalous experiences is longer in the non-clinical group than the clinical group.
5	Cicero et al.[50†] Peters et al.[41] Unterrassner et al.[46†]	Characteristics of the experience	Assess paranoid symptoms	2	Ideas of reference and suspiciousness are more frequent in clinical groups than non-clinical groups.
6	Brett et al.[48] Brett et al.[49] Bronn & McIlwain[42†] Humpston et al.[44†] Jackson & Fulford[39†] Peters et al.[40] Peters et al.[41] Preti et al.[51†] Preti et al.[52†]	Consequences of the experience	Assess the patient's reaction to anomalous content	2	The clinical group acts out delusions with bizarre behavior, experiences greater distress, and loses contact with reality.
7	Brett et al.[48] Jackson & Fulford[39†] Marzanski & Bratton[53†] Peters et al.[41]	Consequences of the experience	Assess how the anomalous experience is embedded in the individual's values, context and beliefs	2	The non-clinical group tends to integrate the experience positively in their life, perceiving it in line with some religious-narrative context or values and are more able to adopt a mindful and accepting attitude, feeling psychological well-being as a result of their experience.
8	Marzanski & Bratton[53‡]	Context and perception of the experience	Assess insight	5	The non-clinical group has greater insight into the unusual quality of their experience than the clinical group.
9	Brett et al.[48] Brett et al.[49] Peters et al.[41]	Context and perception of the experience	Assess the feeling of control during the experience	2	The non-clinical group has more control over the experience than the clinical group and does not usually present with greater

Continued on next page

Table 1 (*continued*)

Criteria	Studies	Specifiers	Recommendation	Level of evidence	Comments
	Moreira-Almeida[45] Damiano et al.[54]				distress when appraising the experience. A feeling of control may be developed after training in some spiritual tradition.
10	Unterrassner et al.[46†] Cicero et al.[50†] Peters et al.[41]	Negative symptoms	Assess negative symptoms	2	The non-clinical group reported fewer negative symptoms and anhedonia than the clinical group.
11	Cicero et al.[50†] Peters et al.[41]	Cognitive factors	Assess cognitive performance	2	The clinical group has more cognitive difficulties, a lower IQ, and more disorganization than the non-clinical group.
12	Brett et al.[48] Peters et al.[41]	Cognitive factors	Assess cognitive style	2	The clinical group has a more negative view of self and others than the non-clinical group.
13	Gabbard et al.[55] Jackson & Fulford[39†] Moreira-Almeida et al.[45] Peters et al.[41] Vencio et al.[47]	Comorbidities	Assess other mental symptoms and disorders	2	The clinical group experiences other mental symptoms and requires antipsychotic medication more frequently than the non-clinical group. The non-clinical group is less likely to be diagnosed with borderline personality disorder and has fewer other mental disorders and less somnambulism than the clinical group with DID. There were no differences in somatic complaints or personality traits between the non-clinical group and the group without anomalous experiences.
14	Unterrassner et al.[46†] Cicero et al.[50†] Escolà-Gascón[43†] Jackson & Fulford[39‡]	Personality	Assess personality traits	3	Harm avoidance, introverted anhedonia, and novelty-seeking predict psychopathology or lower quality of life while self-transcendence, self-directedness, and ego-strength are predictors of better mental health.
15	Peters et al.[41]	Family history	Assess family history of psychosis	3	Family history of psychosis is more frequent in the clinical group than the non-clinical group.
16	Cicero et al.[50†] Moreira-Almeida et al.[45] Vencio et al.[47]	Premorbid history	Assess history of childhood trauma	2	No difference in childhood trauma or psychiatric history between the non-clinical group and the group without anomalous experiences.
17	Moreira-Almeida et al.[45] Peters et al.[41]	Sociodemographic factors	Assess functionality	2	The non-clinical group tends to obtain higher educational levels, have better jobs, and use mental health services less than the clinical group.
18	Brett et al.[49] Peters et al.[41]	Sociodemographic factors	Assess relationship history	2	The non-clinical group enjoys longer relationships and experiences less lifetime discrimination than the clinical group.
19	Gabbard et al.[55]	Sociodemographic factors	Religious affiliation does not differentiate individuals	3	Current religious affiliation did not differentiate the non-clinical group from the group without anomalous experiences.
20	Moreira-Almeida et al.[45]	Sociodemographic factors	Sex does not differentiate individuals	3	No sex differences regarding DID in non-clinical groups.

DID = dissociative identity disorder; IQ = intelligence quotient.
† Studies that included only non-clinical samples.
‡ Case series.

Box 4 Summary of evidence in favor of taking a spiritual history

	Level of evidence	Observations
Improves treatment satisfaction	2	RCT of oncology patients[27] and hospitalized patients[28]
Improves treatment attendance or adherence	2	RCT of patients with schizophrenia[29]
Improves psychological well-being and quality of life	2	RCT including oncology patients[27]
Reduces negative psychological symptoms	2	RCT of oncology patients[27]
SH training improves spiritual assessment in health care	2	Medical students and other health-related undergraduates[37,38]

RCT = randomized controlled trial(s); SH = spiritual history.

1.4. Training in taking a spiritual history

Training is essential in encouraging health professionals to take SHs because it overcomes the main perceived barriers in clinical practice. One randomized controlled trial investigated the efficacy of theoretical-practical training in SH-taking (14 hours of theoretical classes and 10 hours of practical activities with simulations and real-world inpatients over a period of four months) in 49 1st- and 2nd-year students of medicine, nursing, physical therapy, and psychology. Compared to the control group, the intervention group felt more comfortable in taking a SH, more readily recognized the importance of the chaplain, and recognized the importance of spirituality in the professional-patient relationship. In the skills assessment with simulated patients, trained students scored much higher than controls (14.12 vs. 6.17 of a maximum of 17 points).[37]

Another study examined the effectiveness of SH training among 1st-year medical students.[38] The students were expected to use the Hope, Organized Religion, Personal Spirituality, and Effects on Medical Care instrument (HOPE) or similar questions to elicit a spiritual history when practicing their communication and medical interviewing skills during sessions. Of the 146 students included in the study, 65% could recognize the patient's spiritual concerns, demonstrating skills and knowledge in taking a SH 1 to 3 months after the initial learning period. The results suggest that 1st-year medical students can effectively learn about spirituality and medicine as an integrated part of their clinical training, without the need for separate courses to address spiritual issues.[38]

Conclusions

Despite the limited evidence about different strategies for taking a SH, there are a number of benefits to taking a SH in mental health clinical practice (Box 4): i) more compassionate and culturally sensitive care that positively impacts patient outcomes and treatment satisfaction; ii) information about patient R/S beliefs, practices, resources, and struggles that may affect treatment; iii) clearer differential diagnosis between R/S experiences and psychopathology; and iv) identification of individuals who might benefit from specialized spiritual care or counseling from a chaplain. Key recommendations and the main evidence-based questions for conducting the investigation were reviewed and summarized in Boxes 1 and 2.

What evidence should be considered in the differential diagnosis between psychiatric disorders and religious or spiritual experiences?

Another key issue in clinical practice is differential diagnosis between religious, spiritual, or anomalous experiences and psychopathology/mental disorders. To answer this question, we identified 1,170 articles in the databases, of which 987 were screened after removing duplicates. A total of 59 were considered relevant for a full-text reading based on their title and abstract. After a comprehensive full-text reading, 18 were included in the review, in addition to 11 others identified through other sources (Figure S2). The 29 included articles were: nine narrative reviews, 17 cross-sectional studies, one case-control study, and two case series (for details, see Table S6, available as online-only supplementary material). These criteria are explored in greater detail below, focusing on two main points: characteristics of the phenomenon and characteristics of the individual (see Table 1 for suggested criteria and level of evidence for differential diagnosis).

Clinical characteristics and the phenomenology of anomalous experiences

The most commonly studied criteria for differentiating pathological from non-pathological anomalous experiences are the characteristics associated with the experience, including its form and content. Studies agree that perceptual changes (e.g., auditory or visual experiences),[39-47] and thought content (e.g., belief in spiritual influence or telepathy)[40,41,46,48,49] do not differ between clinical and the non-clinical groups (Table 1). These are well-replicated findings.

Regarding the content itself, different narrative reviews have pointed out that the distinction between religious beliefs and delusions may not rely solely on content.[56] This is due to their potential 'phenomenological overlap.'[56] Arnaud et al.[57] concluded that the content of R/S delusions or hallucinations can rarely be used to determine psychosis or a spiritual emergency. Moreover, Lukoff[56] considers that "absolute belief is not a sign of pathology in itself," since "all beliefs that are personally significant tend to be held with absolute conviction."[56] In addition, when assessing qualitative aspects of auditory hallucinations, characteristics such as the voice's volume, personification, location (internal or external), number,

and gender, as well as the detection of underlying brain activity, cannot differentiate between pathological and non-pathological anomalous experiences.[58]

However, other characteristics of the experience may guide clinicians. First, most studies found that paranoid symptoms (e.g., self-reference and suspiciousness)[41,46,50] are more frequently found in clinical groups.[40,41] For example, Peters et al.[41] compared 592 healthy individuals with anomalous experiences to 584 individuals diagnosed with a psychotic disorder, finding that paranoid symptoms were rare in the non-clinical group.

Second, although the experiences of the non-clinical group began at a younger age and have continued longer,[41] loss of contact with consensual reality during the experience tends to be longer in the clinical group.[39]

Narrative reviews also agree that experiencing shorter episodes over the course of a lifetime tends to be related to non-pathological experiences. Prins[59] points out that "states of true possession also tend to be more transient than schizophrenic illnesses," while Lukoff[56] suggests that so-called spiritual experiences tend to be "generally transitory and resolve themselves completely, without leaving residual social difficulties or isolation; in contrast, psychotic disorders usually persist for a long period and involve continual impairment and social withdrawal."[57] Acute onset of symptoms for 3 months or less was considered indicative of a positive psychological outcome.[56]

Third, since clinical groups have less insight into the unusual quality of their experiences,[53] they tend to have more distress and suffering, acting out their experiences in a bizarre way,[39-42,44,48,49,51,52] and have greater difficulty constructively incorporating their experience into their lives.[39,41,48,53] The clinical group also experienced less control over the phenomenon.[41,48,49] For instance, in a study assessing undiagnosed, at-risk, and diagnosed individuals, Brett et al.[49] found that the level of effort exerted in attempting to control the experience was predictive of greater distress, whereas the mere presence of anomalous perception was not.[49] In their reviews, Prins,[59] Lukoff,[56] and Menezes[60] agree that greater passivity would likely be more associated with psychopathological aspects,[56,59] while greater control would be associated with less need for care, since individuals would be "able to direct their experience at the right time and place for its occurrence."[60] It is worth noting that control over the experience can be obtained over time through training in spiritual communities or groups.[54,61]

Finally, cognitive and negative symptoms are probably the most relevant clinical features for distinguishing between pathological and non-pathological anomalous experiences. Clinical groups have greater cognitive impairment, lower intelligence scores, and greater cognitive disorganization.[41,50] It is important to note that non-clinical groups have a greater tendency to interpret their experiences from a spiritual, less materialistic perspective,[48] while clinical groups have a more negative view of self and others.[41] Clinical groups also have more negative symptoms and anhedonia.[41,46,50] Lukoff[56] highlighted the "absence of conceptual disorganization and confusion" as a differentiating criterion between the groups, which could be evidenced by characteristics such as "interruption of thought, incoherence, and blockage."[56] In a prospective study of 115 people who sought help in Spiritist centers in Brazil due to disturbing anomalous/spiritual experiences, quality of life after 1 year was not predicted by baseline levels of anomalous (e.g., perceptual) experiences, but by self-directedness and inversely by cognitive disorganization.[62-64]

Functioning, personality, psychiatric comorbidities, and mental health

Compared to clinical samples, individuals with non-clinical anomalous experiences generally have better mental health, social adjustment,[39,41,47,48] and personality functioning.[39,43,45,46,50] For example, Spiritist mediums had a lower prevalence of mental disorders and lower antipsychotic use than patients with dissociative identity disorder,[45] as well as similar marital status, psychiatric history, education, and income to controls without anomalous experiences.[47]

In general, a lack of medical or psychiatric comorbidities supports categorizing the experience in the "no need for care" group.[58,60] Concerning substance use, some studies reported that non-clinical anomalous experience groups are less likely to use substances than clinical groups,[41] while others found no difference between mediums and healthy controls regarding substance abuse.[47] Regarding potential biological markers for differentiating R/S or anomalous experiences, the brain's resting-state network in mediums did not differ from matched healthy controls.[65]

Family and premorbid history may help clinicians differentiate clinical from non-clinical individuals with anomalous experiences. A family history of psychosis is more frequent in clinical groups,[41] but the age of onset is earlier in non-clinical groups.[41,45] Functionality is another important issue to be assessed since non-clinical groups tend to have higher education, better jobs, and use mental health services less often than clinical groups.[41,45] They also report longer relationships and less lifetime discrimination.[41,49] There were no significant differences between clinical and non-clinical groups regarding current religious affiliation[55] or sex.[45]

Many authors emphasized the importance of pre-episodic functioning.[66-68] In this sense, if "the history demonstrates generally healthy social, psychological, spiritual, and sexual functioning, then the person's current experience is viewed as psychospiritual and suggestive of a positive prognosis. In contrast, a history of dysfunction, as well as strong evidence of manic symptoms, poorly organized content in religious, spiritual, or transcendent experiences, self-destructive tendencies, and the presence of persecutory delusions or hallucinations may be indicative of psychopathology.[69]

Most studies found no differences concerning common mental disorders and symptoms between clinical and non-clinical groups with anomalous experiences. One study,[47] for example, found no difference in the prevalence of major depressive episodes between mediums and healthy controls.[39,41,45,47,55] Conversely, other studies found a higher anxiety level in non-clinical groups

with anomalous/spiritual experiences.[55,64] One hypothesis is that spiritual/anomalous experiences may induce anxiety in individuals who lack a cognitive framework and/or support group to help create meaning and integrate these experiences in a healthy way.[17]

Most of the included studies found that paranormal beliefs did not differ phenomenologically between clinical and non-clinical groups.[40,41,46,48,49] One study reported that the frequency and intensity of psychotic-like experiences were higher among healthy believers in the paranormal than among healthy skeptics.[52] Both were non-clinical samples and psychological distress levels between groups were comparable, suggesting that both were healthy.

There is one contradictory finding regarding personal history of trauma. Studies by Cicero et al.,[50] Moreira-Almeida et al.,[45] and Vencio et al.[47] found no differences in childhood trauma between non-clinical groups and groups without anomalous experience, while Peters et al.[41] reported that the number of childhood traumatic events was similar between non-clinical and clinical groups and higher in the non-clinical group than the control group.

Patient perspectives about religious or spiritual experiences

Even among patients whose R/S experiences are associated with psychopathology and a psychiatric diagnosis, a sensitive, respectful, and considerate approach to their perception and interpretation of their experiences is recommended, especially after resolving an acute crisis.[70,71] To many individuals, R/S perceptions eventually become a source of faith, hope, community integration, resilience, meaning, and long-term psychological well-being following resolution of acute psychiatric episodes.[70] To others, R/S experiences might be a source of struggle, and clinicians should also be aware of this. So, even in psychotic patients, spiritual phenomena may not necessarily represent a mental symptom but a source of mental health. A patient-centered, respectful acknowledgement of the patient's perspectives is extremely important in psychiatry because of the persistent negative stereotypes that can affect people with mental disorders, leading to the discrediting of their beliefs and views.[72] In a sample of patients with bipolar disorder, after resolving manic episodes, most reported viewing their experiences as both authentically R/S but also related to the disorder, reinforcing the complex relationship between R/S and mental health care.[73] Accordingly, a comprehensive spiritually-integrated approach is a way to include/reconcile patient beliefs with the best available treatment and help improve patient satisfaction and treatment adherence (e.g., antipsychotics for psychotic disorders), thereby encouraging full recovery.

Conclusions

A number of clinical characteristics that might help differentiate non-pathological anomalous/spiritual experiences from mental disorders have been studied. A careful and comprehensive psychiatric evaluation is recommended to provide reliable clinical information for a differential psychiatric diagnosis. The high prevalence of anomalous or religious experiences in the general population reinforces the need for a culturally sensitive and evidence-based integrated approach to determine the types more correlated with psychopathology and those that do not require psychiatric treatment. To illustrate this distinction in clinical practice, case reports by Damiano et al.[54] and Delmonte et al.[61] describe individuals who had disturbing anomalous experiences that were later assimilated as healthy lifelong spiritual experiences, going on to become productive and respected spiritual leaders.

There is consistent evidence that non-pathological anomalous/spiritual experiences cannot normally be distinguished from mental disorders based solely on perceptual experiences ("positive symptoms"). However, distinctions could be made using negative symptoms, cognitive and behavioral disorganization, functional impairment, and other markers of mental disorders that are not directly associated with R/S aspects (e.g., paranoid, manic, or depressive symptoms).

The present study and systematic review should be viewed in light of several limitations. First, the challenge of summarizing and consolidating the many heterogeneous studies to answer the clinical questions is the main limitation. The limited number of randomized trials on specific SH protocols is another limitation to more conclusive statements and more specific recommendations. Studies from diverse clinical settings and cultural backgrounds are needed to understand the effects of R/S-integrated care, especially in Latin America and Brazil.

General conclusions

There is consistent and varied evidence (although limited in certain aspects) to support the integration of spirituality into clinical practice. We hope the present guidelines will help bridge the gap between the evidence and integration of R/S into mental health care assessment and differential psychiatric diagnosis. It cannot be emphasized strongly enough that any integration of R/S into clinical practice must be patient-centered, never imposing beliefs or practices, and only applied to those who are open-minded and welcome such integration. Access to high-quality scientific research into R/S and mental health, as well as continued medical education and training, might help overcome barriers and improve R/S assessment and integration in mental health care. Based on the reviewed research, the following recommendations can be made:

1. A SH should be routinely taken in psychiatric patients as an essential part of the psychiatric interview to assess the patient's R/S beliefs, experiences, and practices, especially regarding potential R/S resources and/or struggles.
2. Distinction between cultural, anomalous, R/S experiences and mental disorders: the best markers for mental disorders are negative psychotic and cognitive disorganization symptoms, as well as functional impairment and other symptoms indicative of comorbid mental disorders.

Acknowledgements

The authors would like to express their deep appreciation to all Brazilian Psychiatric Association colleagues who supported the preparation of these guidelines, in addition to Professor Christopher C. H. Cook, Chair of the Spirituality Special Interest Group of the Royal College of Psychiatrists, for relevant references regarding epistemic injustices, differential diagnosis of R/S experiences, and psychopathology.

References

1 Koenig HG, Al-Zaben F, VanderWeele TJ. Religion and psychiatry: recent developments in research. BJPsych Advances. 2020;26:1-11.
2 Pew Research Center. The changing global religious landscape. 2017. https://www.pewresearch.org/religion/2017/04/05/the-changing-global-religious-landscape/
3 Moreira-Almeida A, Pinsky I, Zaleski M, Laranjeira R. Religious involvement and sociodemographic factors: a Brazilian national survey. Arch Clin Psychiatry. 2010;37:12-5.
4 King MB, Koenig HG. Conceptualising spirituality for medical research and health service provision. BMC Health Serv Res. 2009; 9:1-7.
5 Moreira-Almeida A, Bhugra D. Religion, spirituality, and mental health: setting the scene. In: Moreira-Almeida A, Mosqueiro BP, Bhugra D, editors. Spirituality and mental health across cultures. Oxford: Oxford University Press; 2021.
6 Koenig HG, King DE, Benner CV. Handbook of religion and health. 2nd ed. Oxford: Oxford University Press; 2012.
7 Rosmarin DH, Pargament KI, Koenig HG. Spirituality and mental health: challenges and opportunities. Lancet Psychiatry. 2021;8:92-3.
8 Braam AW, Koenig HG. Religion, spirituality and depression in prospective studies: A systematic review. J Affect Disord. 2019;257:428-38.
9 Stroppa A, Colugnati FA, Koenig HG, Moreira-Almeida A. Religiosity, depression, and quality of life in bipolar disorder: a two-year prospective study. Braz J Psychiatry. 2018;40:238-43.
10 Beraldo L, Gil F, Ventriglio A, Andrade AG, Silva AG, Torales J, et al. Spirituality, religiosity and addiction recovery: current perspectives. Curr Drug Res Rev. 2019;11:26-32.
11 Caribé AC, Studart P, Bezerra-Filho S, Brietzke E, Noto MN, Vianna-Sulzbach M, et al. Is religiosity a protective factor against suicidal behavior in bipolar I outpatients? J Affect Disord. 2015;186:156-61.
12 VanderWeele TJ, Li S, Tsai AC, Kawachi I. Association between religious service attendance and lower suicide rates among US women. JAMA Psychiatry. 2016;73:845-51.
13 Pargament KI, Zinnbauer BJ, Scott AB, Butter EM, Zerowin J, Stanik P. Red flags and religious coping: identifying some religious warning signs among people in crisis. J Clin Psychol. 1998;54:77-89.
14 Rosmarin DH, Malloy MC, Forester BP. Spiritual struggle and affective symptoms among geriatric mood disordered patients. Int J Geriatr Psychiatry. 2014;29:653-60.
15 Pargament KI, Lomax JW. Understanding and addressing religion among people with mental illness. World Psychiatry. 2013;12:26-32.
16 Lomax JW, Kripal JJ, Pargament KI. Perspectives on ''sacred moments'' in psychotherapy. Am J Psychiatry. 2011;168:12-8.
17 Machado L, Moreira-Almeida A. Differentiating spiritual experiences from mental disorders. In: Moreira-Almeida A, Mosqueiro BP, Bhugra D, editors. Spirituality and mental health across cultures. London: Oxford University Press; 2021.
18 Moreira-Almeida A, Koenig HG, Lucchetti G. Clinical implications of spirituality to mental health: review of evidence and practical guidelines. Braz J Psychiatry. 2014;36:176-82.
19 De Oliveira FHA, Peteet JR, Moreira-Almeida A. Religiosity and spirituality in psychiatry residency programs: why, what, and how to teach? Braz J Psychiatry. 2021;43:424-9.
20 Moreira-Almeida A, Sharma A, van Rensburg BJ, Verhagen PJ, Cook CC. WPA Position Statement on Spirituality and Religion in Psychiatry. World Psychiatry. 2016 Feb;15:87-8.
21 Howick J, Chalmers I, Glasziou P, Greenhalgh T, Heneghan C, Liberati A, et al. Explanation of the 2011 Oxford Centre for Evidence-Based Medicine (OCEBM) Levels of Evidence (Background Document). https://www.cebm.ox.ac.uk/files/levels-of-evidence/cebm-levels-of-evidence-background-document-2-1.pdf
22 Whiting P, Savović J, Higgins JP, Caldwell DM, Reeves BC, Shea B, et al. ROBIS: A new tool to assess risk of bias in systematic reviews was developed. J Clin Epidemiol. 2016;69:225-34.
23 Sterne JAC, Savović J, Page MJ, Elbers RG, Blencowe NS, Boutron I, et al. RoB 2: a revised tool for assessing risk of bias in randomised trials. BMJ. 2019;366:l4898.
24 Moola S, Munn Z, Tufanaru C, Aromataris E, Sears K, Sfetcu R, et al. Chapter 7: Systematic reviews of etiology and risk. In: Aromataris E, Munn Z, editors. Joanna Briggs Institute Reviewer's Manual. 2020. https://reviewersmanual.joannabriggs.org/
25 Kao L, Peteet JR. Spiritually and culturally sensitive evidence-based approaches to taking a spiritual history. In: Moreira-Almeida A, Mosqueiro BP, Bhugra D, editors. Spirituality and mental health across cultures. Oxford: Oxford University Press; 2021.
26 Puchalski C, Ferrell B, Virani R, Otis-Green S, Baird P, Bull J, et al. Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. J Palliat Med. 2009; 12:885-904.
27 Kristeller JL, Rhodes M, Cripe LD, Sheets V. Oncologist Assisted Spiritual Intervention Study (OASIS): patient acceptability and initial evidence of effects. Int J Psychiatry Med. 2005;35:329-47.
28 Williams JA, Meltzer D, Arora V, Chung G, Curlin FA. Attention to inpatients' religious and spiritual concerns: predictors and association with patient satisfaction. J Gen Intern Med. 2011;26:1265-71.
29 Huguelet P, Mohr S, Betrisey C, Borras L, Gillieron C, Marie AM, et al. A randomized trial of spiritual assessment of outpatients with schizophrenia: patients' and clinicians' experience. Psychiatr Serv. 2011;62:79-86.
30 Moreira-Almeida A, Cardeña E. Differential diagnosis between non-pathological psychotic and spiritual experiences and mental disorders. Braz J Psychiatry. 2011;33:29-36.
31 Vermandere M, Warmenhoven F, Van Severen E, De Lepeleire J, Aertgeerts B. Spiritual history taking in palliative home care: A cluster randomized controlled trial. Palliat Med. 2016;30:338-50.
32 Menegatti-Chequini MC, Gonçalves JP, Leão FC, Peres MF, Vallada H. A preliminary survey on the religious profile of Brazilian psychiatrists and their approach to patients' religiosity in clinical practice. BJPsych Open. 2016;2:346-52.
33 Best M, Butow P, Olver I. Doctors discussing religion and spirituality: A systematic literature review. Palliat Med. 2016;30:327-37.
34 Best M, McArdle MB, Huang YJ, Clayton J, Butow P. How and how much is spirituality discussed in palliative care consultations for advanced cancer patients with and without a question prompt list? Patient Educ Couns. 2019;102:2208-13.
35 Lucchetti G, Bassi RM, Lucchetti AL. Taking spiritual history in clinical practice: a systematic review of instruments. Explore (NY). 2013; 9:159-70.
36 Paal P, Helo Y, Frick E. Spiritual care training provided to healthcare professionals: a systematic review. J Pastoral Care Counsel. 2015; 69:19-30.
37 Osório IHS, Gonçalves LM, Pozzobon PM, Gaspar Jr JJ, Miranda FM, Lucchetti ALG, et al. Effect of an educational intervention in ''spirituality and health'' on knowledge, attitudes, and skills of students in health-related areas: A controlled randomized trial. Med Teach. 2017;39:1057-64.
38 King DE, Blue A, Mallin R, Thiedke C. Implementation and assessment of a spiritual history taking curriculum in the first year of medical school. Teach Learn Med. 2004;16:64-8.
39 Fulford KWM, Jackson M. Spiritual experience and psychopathology. Philos Psychiatr Psychol. 1997;4:41-65.
40 Peters ER, Joseph SA, Garety PA. Measurement of delusional ideation in the normal population: introducing the PDI (Peters et al. Delusions Inventory). Schizophr Bull. 1999;25:553-76.
41 Peters E, Ward T, Jackson M, Morgan C, Charalambides M, McGuire P, et al. Clinical, socio-demographic and psychological characteristics in individuals with persistent psychotic experiences with and without a ''need for care''. World Psychiatry. 2016;15:41-52.
42 Bronn G, McIlwain D. Assessing spiritual crises: peeling off another layer of a seemingly endless onion. J Humanist Psychol. 2015;55: 345-82.
43 Escolà-Gascón Á. Researching unexplained phenomena II: new evidences for anomalous experiences supported by the Multivariable

Multiaxial Suggestibility Inventory-2 (MMSI-2). Curr Res Behav Sciences. 2020;1:100005.
44 Humpston CS, Walsh E, Oakley DA, Mehta MA, Bell V, Deeley Q. The relationship between different types of dissociation and psychosis-like experiences in a non-clinical sample. Conscious Cogn. 2016;41:83-92.
45 Moreira-Almeida A, Neto FL, Cardeña E. Comparison of brazilian spiritist mediumship and dissociative identity disorder. J Nerv Ment Dis. 2008;196:420-4.
46 Unterrassner L, Wyss TA, Wotruba D, Haker H, Rössler W. The intricate relationship between psychotic-like experiences and associated subclinical symptoms in healthy individuals. Front Psychol. 2017;8:1537.
47 Vencio S, Caiado-Vencio R, Caixeta L. Differential diagnosis between anomalous experiences and dissociation disorder using the Dissociative Disorders Interview Schedule (DDIS). J Trauma Dissociation. 2019;20:165-78.
48 Brett CM, Peters EP, Johns LC, Tabraham P, Valmaggia LR, McGuire P. Appraisals of Anomalous Experiences Interview (AANEX): a multidimensional measure of psychological responses to anomalies associated with psychosis. Br J Psychiatry Suppl. 2007; 51:s23-30.
49 Brett C, Heriot-Maitland C, McGuire P, Peters E. Predictors of distress associated with psychotic-like anomalous experiences in clinical and non-clinical populations. Br J Clin Psychol. 2014;53:213-27.
50 Cicero DC, Gawęda Ł, Nelson B. The placement of anomalous self-experiences within schizotypal personality in a nonclinical sample. Schizophr Res. 2020;218:219-25.
51 Preti A, Bonventre E, Ledda V, Petretto DR, Masala C. Hallucinatory experiences, delusional thought proneness, and psychological distress in a nonclinical population. J Nerv Ment Dis. 2007;195:484-91.
52 Preti A, Cella M, Raballo A, Vellante M. Psychotic-like or unusual subjective experiences? The role of certainty in the appraisal of the subclinical psychotic phenotype. Psychiatry Res. 2012;200:669-73.
53 Marzanski M, Bratton M. Psychopathological symptoms and religious experience: a critique of Jackson and Fulford. Philos Psychiatr Psychol. 2002;9:359-371.
54 Damiano RF, Machado L, Loch AA, Moreira-Almeida A, Machado L. Ninety years of multiple psychotic-like and spiritual experiences in a Doctor Honoris Causa: a case report and literature review. J Nerv Ment Dis. 2021;209:449-53.
55 Gabbard GO, Twemlow SW, Jones FC. Differential diagnosis of altered mind/body perception. Psychiatry. 1982;45:361-9.
56 Lukoff D. Visionary spiritual experiences. South Med J. 2007;100: 635-41.
57 Arnaud KOS, Cormier DC. Psychosis or spiritual emergency: the potential of developmental psychopathology for differential diagnosis. Int J Transpers Stud. 2017;36:44-59.
58 Johns LC, Kompus K, Connell M, Humpston C, Lincoln TM, Longden E, et al. Auditory verbal hallucinations in persons with and without a need for care. Schizophr Bull. 2014;40 Suppl 4:S255-64.
59 Prins H. Besieged by devils--thoughts on possession and possession states. Med Sci Law. 1992;32:237-46.
60 Menezes Jr A, Moreira-Almeida A. Religion, spirituality, and psychosis. Curr Psychiatry Rep. 2010;12:174-9.
61 Delmonte R, Lucchetti G, Moreira-Almeida A, Farias M. Can the DSM-5 differentiate between nonpathological possession and dissociative identity disorder? A case study from an Afro-Brazilian religion. J Trauma Dissociation. 2016;17:322-37.
62 Alminhana LO, Farias M, Claridge G, Cloninger CR, Moreira-Almeida A. How to tell a happy from an unhappy schizotype: personality factors and mental health outcomes in individuals with psychotic experiences. Braz J Psychiatr. 2017;39:126-32.
63 Alminhana LO, Farias M, Claridge G, Cloninger CR, Moreira-Almeida A. Self-directedness predicts quality of life in individuals with psychotic experiences: A 1-year follow-up study. Psychopathology. 2017;50:239-45.
64 Menezes Jr A, Alminhana L, Moreira-Almeida A. Sociodemographic and anomalous experiences profile in subjects with psychotic and dissociative experiences in religious groups. Rev Psiq Clin. 2012; 39(6):203-7.
65 Mainieri AG, Peres JFP, Moreira-Almeida A, Mathiak K, Habel U, Kohn N. Neural correlates of psychotic-like experiences during spiritual-trance state. Psychiatry Res Neuroimaging. 2017;266:101-7.
66 Bragdon E. A sourcebook for helping people with spiritual problems. Aptos: Lightening Up Press; 1993.
67 Cortright B. Psychotherapy and spirit: Theory and practice in transpersonal psychotherapy. Albany: State University of New York Press; 1997.
68 Grof S, Grof C. The stormy search for self: A guide to personal growth through transformational crisis. New York: Tarcher; 1992.
69 Johnson CV, Friedman HL. Enlightened or delusional? Differentiating religious, spiritual, and transpersonal experiences from psychopathology. J Humanist Psychol. 2008;48:505-27.
70 Mohr S, Brandt PY, Borras L, Gilliéron C, Huguelet P. Toward an integration of spirituality and religiousness into the psychosocial dimension of schizophrenia. Am J Psychiatry. 2006;163:1952-9.
71 Mohr S, Huguelet P. The wishes of outpatients with severe mental disorders to discuss spiritual and religious issues in their psychiatric care. Int J Psychiatry Clin Pract. 2014;18:304-7.
72 Crichton P, Carel H, Kidd IJ. Epistemic injustice in psychiatry. BJPsych Bull. 2017;41:65-70.
73 Ouwehand E, Muthert H, Zock H, Boeije H, Braam A. Sweet delight and endless night: a qualitative exploration of ordinary and extraordinary religious and spiritual experiences in bipolar disorder. Int J Psychol Relig. 2018;28:31-54.