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Empathy and mental health associated with non-conventional healing practices

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ABSTRACT

The aim of this study was to evaluate empathy and mental health in individuals who practice spiritual healing techniques. A sample of 190 healing practitioners was recruited to evaluate the healing experiences, along with to test cognitive-perceptual deficit and empathy. Significant differences were found due to age in two groups (Practitioners, $n = 71$, and Newly initiated, $n = 119$). Practitioners scored high on cognitive and affective empathy and proneness for cognitive and social schizotypy compared to the newly initiated. An secondary analysis also showed positive correlations between the total score of healing modalities and both schizotypy and empathy, as well as higher scores of spirituality and training in various healing techniques. These and other findings may allowed us to build a personality profile of healers as characterized by an adaptive dissociative personality trait and the ability to establish links with their clients/patients.

KEYWORDS

Healing; schizotypy; empathy; spirituality

Introduction

Many healers believe that some type of "energy" is involved in the healing process; hence the growing acceptance of "energy-based" healing modalities such as Reiki, Therapeutic Touch and Qigong (Levin, 1996; Wisneski & Anderson, 2009). Although the concept of *energy* is somewhat vague and ambiguous, it is the modern metaphor for the interpretation of exceptional experiences (ExE) associated with healing practices (Benor, 2001; Krippner & Achterberg, 2000). This is unlike other expressions, such as *fluid* or animal magnetism, that were fashionable in the 18th and 19th centuries. Some types of ExE are "seeing the aura or lights around a patient's body,""interacting with spiritual guides," and "miraculous recoveries." Such experiences, however strange and unusual, are common among healers, but they largely lack

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research by the medical academic community, due to the complexity of the healing process, which links the fields of medicine, physics, and psychology (Dossey, 2006).

A previous study of a sample of Argentine healers found that the sensory modalities subjectively perceived by them in their practices were (1) the sensation of movement and "flow" (kinetic); (2) the "sensation of liberation" (relief); (3) vision of lights and energies; (4) hearing voices; and (5) the prone to be predominantly more visual and auditory compared to a group of the newly initiated. These experiences also contain a "transpersonal" quality, that is, they tend to increase the healers' perspective in emotional and bodily awareness and greater absorption/dissociation, as well as greater spirituality and training in various healing techniques (Parra & Giudici, 2020).

A subsample of healers aimed to compare practitioners trained in cognitive or in affective empathic qualities, and evaluate deficit indicators in their cognitive and perceptual processes (or their schizotypy proneness). For example, relatively few studies have examined the personality and psychopathological features of healing practitioners. Indeed, it has traditionally been thought that shamanic practices are among the indicators of a proneness for schizophrenia in individuals who are "believers in the supernatural" (Claridge, 1997; Parra & Espinoza, 2009; Wolfradt, Oubaid, Straube, Bischoff, & Mischo, 1999), a category that tends to include a certain dose of cultural contempt (Luke, 2010; Winkelman, 2011, 2017).

However, at least two dimensions of the propensity for schizotypy have been observed: the positive dimension, or "unusual perceptual experiences," including various forms of hallucinations, paranoid ideation, reference ideas, and thinking disorders, and the negative dimension, known as "anhedonia" or "interpersonal deficit," which refers to the decrease or deficit in the normal behavior of individuals who have difficulty experiencing pleasure at physical and social levels, flattened affection, absence of intimate confidants, and difficulties in their interpersonal relationships. It is possible that many healing practitioners score high on these measures because, clinically, their practices are usually associated with beliefs and experiences that may be dysfunctional for neophyte observers (Parra, 2011, 2012, 2015; Parra & Espinoza, 2009). For example, when Appelbaum (1993) interviewed 26 healers and administered projective techniques, including the Rorschach stain test, he concluded that, while three healers had severe psychiatric disorders, others were mentally healthy and did not suffer from any indicators of mental impairment. As a group, the healers' responses reflected exaggerated "self-confidence and narcissism, however humble they try to show themselves" (p. 37).

Empathy is also a fundamental variable in emotional intelligence due to its important applications in clinical (Harpur, Hakstian, & Hare, 1988), educational (Miller & Eisenberg, 1988), and organizational (Kellet, Humphrey, & Sleeth, 2006) settings. Although different theories have tried to explain

empathy (for a review, see Fernández-Pinto, López-Pérez, & Márquez, 2008), one of the most accepted definitions is that proposed by Davis (1996), who understood empathy as a set of constructs that include the process of putting oneself in the place of the other, along with both affective and non-affective responses (Eisenberg & Strayer, 1987; Fernández-Pinto et al., 2008).

As regard the healers, the first act of spiritual treatment is the "empathic commitment to the healed," or putting oneself in the place of the sick person and his or her suffering (Benor, 1994a, 1994b). This occurs through the practice of the laying on of hands, that is, when healers put their hands in contact with the patient's body and practice "passes," or hand movements, around it. This process sometimes takes several minutes, during which healers are aware of various sensations in their hands or throughout their body; for example, healers experience heat, cold, tingling, and itching in their hands through touching the patient's/client's body (Benor, 1992).

In an analysis of healers' cognitive styles, Cooperstein (1992) indicated that there is a tendency in healers to use mental images in the process, to the point of feeling that they are "merging" with the patient. Such mental images of healers are symbols of their belief systems. Appelbaum (1993) also suggested that healers may have differential personality characteristics related to the NEO-PI-R Experience Opening dimension, and have high levels of confidence in their power to heal. Borysenko (1985) suggested that the healers she interviewed were characterized by an empathic profile associated with their need to assist, guide, advise, or heal others, which could be considered a strong feature that distinguishes those who practice healing.

In another recent study (Parra, 2018), 235 individuals (20%) of the general population who indicated they had had the experience of "reducing the pain of another person just by touching or thinking about it" showed positive correlations between the frequency of this experience and empathy (r =.21, $p < .001$), including cognitive empathy (putting oneself in the place of the bereaved) and positive affect (feeling pleasure for the relief of the bereaved). These were the most robust correlations, except for negative affect. Other studies of nurses (Parra, 2017) and tarot practitioners (Parra & Sciacca, 2017) showed similar correlations.

The question here is, to what extent do healing experiences in practitioners relate to personality traits? To answer this question, we predicted that experienced practitioners would score high on (H1) positive (but not negative) schizotypy score and on (H2) cognitive and affective empathy compared to the "newly initiated." In addition, a positive and significant correlation was predicted to be found between the frequency of healing experience with (H3) schizotypy proneness, and (H4) cognitive and affective empathy in both practitioners and the newly initiated.

Method

The total sample consisted of 190 practitioners of energy healing techniques, 63 (33%) men and 127 (67%) women, with an age range of 18 to 79 years (Mean = 44.54 years; SD = 13.25 years). The sample came was recruited from a wide variety of institutes, centers, and foundations specializing in New Age activities, meditation and wellness centers, as well as individuals who practice spiritual healing (whether as professionals or amateurs), Yoga centers, and alternative/integrative therapies or practices. Participants were also found through advertisements on the web (via social networks, e.g., Facebook, Twitter, and Instagram), magazines, and online newsletters specializing in spiritual practices (Buddhist and non-religious), bioenergetics, and complementary medicine. This variety of contacts was designed to recruit a sufficiently representative sample of a wide diversity of healing practitioners.

Procedure

A non-probabilistic sampling technique to identify practitioners trained in one (or more than one) healing technique was used. All participants completed the scales individually. Although they received information about the general objectives of the study, in order to avoid bias in their responses, they were not informed of the study hypotheses, and were invited to participate anonymously and voluntarily. Healing practitioners and the newly initiated were recruited ex post facto. All participants completed the scales as unpaid volunteers, having signed an Consent form to participate in the study. The study reviewed an institutional review board (UAI-IRB # 23–24465-654).

Inclusion/exclusion criteria

After sharing a short definition of *healing practices*, we deliberately selected participants from among individuals who attended to their clients/consultants either free of charge or for fees, and whose healing procedures were limited to: (1) the laying on of hands without direct physical contact with the client/patient (e.g., massage), kinetic activity, or therapies (e.g., dance therapy, or anything involving patient/client movements); (2) group treatment (e.g., healing in groups); (3) healing interventions mediated by religious contexts (e.g., evangelical, African American, or other cult groups); and/or (4) distance healing techniques, or intercessory prayer without eye contact with the patient. Questionnaires that were incomplete, incorrectly completed, defective, or showing insurmountable errors or omissions were also ruled out based on the instructions that were given to complete them.

Measures

Survey of Healing Experiences – Revised (*HES–R* Moga, 2017). It is a self-administered scale of 22 items with a 3-point response scale (0 = Never, 1 = Once, 2 = Multiple times). It contains six subscales: (1) Type of Technique (e.g., Reiki, Magnified Healing, Imposition of Hands, Johrei, etc.); (2) Seniority as a healer or practitioner (e.g., "0–2 years" until "More than 20 years "); (3) Visual experiences (e.g., " Colors or lights "); (4) Auditory experiences (e.g., "Voices or music"); (5) Tactile experiences (e.g., "Electric current, static or sparks "; (6) Kinetic experiences (e.g., "Heat or tingling in my hands "); (8) Olfactory/Gustative experiences (e.g., "Roses and floral aromas"or "Fetid, rancid, flatulent or putrid smells"); and (9) Changes in the client/patient during healing sessions (e.g., "Feeling of liberation"). The internal reliability of the HES-R is good, with a Cronbach alpha coefficient = 0.91 (for this sample) and high reliability and test-re-test (Moga, 2017).

Oxford-Liverpool Inventory of Feelings and Experiences – Abbreviated (O-LIFE-A; Mason, Claridge, & Jackson, 1995). It is a self-administered questionnaire of 40 items of dichotomous value (YES/NO) that measures propensity for perceptual cognitive schizotypy. Four subscales are evaluated: (1) Unusual Experiences (e.g., are your thoughts sometimes so loud that you can almost hear them?"); (2) Cognitive Disorganization (e.g., "Do you feel easily hurt when people find fault with you or your work?"); (3) Introverted Anhedonia (e.g., "Do you enjoy singing with other people?"); and (4) Impulsive Disagreement (e.g., "Do you sometimes feel the urge to do something harmful or shocking?"). These subscales also have high internal consistency (Alpha = .79). A combination of the four sub-scales allows for the evaluation of two schizotypy sub-factors, which are derived from the sum of the scores of the subscales: Unusual Experiences +

Table 1. Comparison of schizotypy and empathy between initiates and healing practitioners.

	Initiates (n = 119)		Practitioners (n = 71)				
	Mean	SD	Mean	SD	z*	p	e_s
1. Unusual Experiences	5.91	2.46	6.75	2.45	2.67	.007	.34
2. Cognitive Disorganization	4.03	2.48	2.03	1.85	5.45	<.001	.91
3. Introverted Anhedonia	4.31	1.68	4.52	1.52	0.71	n.s.	.13
4. Impulsive Nonconformity	3.50	1.99	2.01	1.58	5.13	<.001	.82
F1. Positive Schizotypy	9.94	3.21	8.77	2.90	2.48	.01	.38
F2. Negative Schizotypy	7.82	2.87	6.54	2.22	2.99	.003	.49
Schizotypy	17.75	4.66	15.30	3.72	3.89	<.001	.58
1. Adoption of Perspectives	26.29	5.58	29.51	4.73	4.13	<.001	.62
2. Empathic Comprehension	31.53	6.53	35.06	6.20	3.49	<.001	.55
3. Empathic Stress	23.51	4.38	23.31	4.44	0.31	n.s.	.04
4. Empathic Joy	28.16	6.10	32.41	5.16	4.45	<.001	.75
F1. Cognitive Empathy	57.82	11.40	64.57	9.85	3.82	<.001	.63
F2. Affective Empathy	51.67	8.00	55.73	7.50	3.65	<.001	.52
Empathy	109.5	18.23	120.30	16.04	3.85	<.001	.62

* Mann-Whittney *U* was used.
(1) Bonferroni correction, p =.0012; df = 189.

Table 2. Correlation between sensory modalities of healing practices with schizoptypy and empathy (N = 190)[1].

Measures	Visual	Auditory	Tactile	Kinesthetic	Olfactory	Changes in the Client	HES–R
1. Positive Schizotypy	.13	.25***	.25**	.11	.12	.12	.23**
2. Negative Schizotypy	−.01	−.14	.009	.27***	.25***	.18*	.13
Schizotypy	.07	.07	.14*	.23**	.22**	.19**	.23**
1. Cognitive Empathy	.47***	.47**	.46**	−.09	−.06	−.17*	.19
2. Affective Empathy	.41**	.45**	.33**	−.10	−.08	−.24**	.11
Empathy	.46**	.47**	.42**	−.08	−.07	−.21**	.16

* p <.05; ** p <.01; *** p <.001[1]
Bonferroni Correction, p =.0006; df = 189.

Table 3. Comparison between healers in schizotypy prone and empathy.

Measures	N	Mean Population	SD	N	Mean Healers	SD	$t^{(1)}$	p_{dif}	e_s
1.Positive Schizotypy	250	6.16	4.01	190	9.51	3.14	14.64	<.001	.93
2.Negative Schizotypy	250	6.62	2.55	190	7.34	2.71	3.64	<.001	.27
Schizotypy	250	14.22	5.61	190	16.84	4.48	8.05	<.001	.51
1.Cognitive Empathy	1156	30.65	6.18	190	32.84	6.64	4.53	<.001	.34
2.Affective Empathy	1156	30.99	5.73	190	29.74	6.11	2.82	.01	.21
Empathy	1156	112.06	14.64	190	113.50	18.17	1.08	n.s.	.08

[1]df = 189. Bonferroni correction, p =.007

Cognitive Disorganization (Positive Schizotypy), and Introverted Anhedonia + Impulsive Nonconformity (Negative Schizotypy). The "positive" dimension, which refers to distorted operation, includes various forms of hallucinations, paranoid ideation, and reference ideas; the "negative" dimension, known as anhedonia or interpersonal deficit, refers to the difficulties in experiencing pleasure on both, physical and social levels, affective flattening, absence of close confidants and friends, and difficulties in interpersonal relationships. This scale offers high internal validity (Cronbach's alpha = .72) and high test-retest reliability of (r = .82) (Parra, 2011).

Test of Affective Cognitive Empathy (TECA: Davis, 1996; López-Pérez, Fernández, & Abad, 2008; Pérez-Albéniz, Paúl, Etxeberría, Montes, & Torr, 2003). This questionnaire has 33 items subdivided into 4 scales: (1) Adoption of perspective, which assesses the capacity for tolerance, communication, and

Table 4. Correlation of schizoptypy and empathy with degree of spirituality, hours, and age (N = 190)[3].

Measures	*Spirituality*[1]	*Hourly Load*[2]	*Age*
1. Positive Schizotypy	−.06	.03	−.16*
2. Negative Schizotypy	−.40***	−.24***	−.32***
Schizotypy	−.30***	−.14*	−.31***
2. Cognitive Empathy	.52***	.41***	.23***
2. Affective Empathy	.52***	.35***	.25**
Empathy	.54***	.40***	.22***

*p <.01; ** p <.01; ***p <.001
[1]Range = I am not spiritual (0) to I am extremely spiritual (4).
[2]Range = 0–5 hours per month (1) to More than 20 hours per month (4).
[3]Bonferroni correction, p =.0012; df = 189.

Table 5. Comparison between low and high *hes* – ren schizotypy and empathy.

	Low *HES* – *R* (*n* = 116)		High *HES* – *R* (*n* = 74)				
Measures	*Mean*	*SD*	*Mean*	*SD*	*z**	*p*	e_s
1. Positive Schizotypy	8.72	2.89	10.74	3.15	4.19	<.001	.66
2. Negative Schizotypy	7.16	2.76	7.62	2.62	1.08	n.s.	.17
Schizotypy	**15.87**	**4.46**	**18.36**	**4.11**	**3.55**	**<.001**	**.58**
1. Cognitive Empathy	57.03	10.53	65.55	10.56	5.21	<.001	.80
2. Affective Empathy	51.47	7.65	55.88	7.96	3.59	<.001	.56
Empathy	108.51	17.24	121.42	16.86	4.69	<.001	.75

* Bonferroni correction, p =.004; df = 189

personal relationships; (2) Emotional understanding, which assesses the ability to recognize the emotional states of others, as well as their intentions and impressions; (3) Empathic stress, which refers to the connection with the negative emotional states of others; and (4) Empathic joy, which refers to the ability to share other people's positive emotions. Perspective Adoption and Emotional Understanding constitute the "cognitive" factor of empathy, while Empathic Stress and Empathic Joy constitute the "emotional" or affective factor of empathy. The types of responses correspond to a Likert scale, with 1 = Strongly disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, and 5 = Strongly agree. In this study, the Spanish version of the Interpersonal Reactivity Index (IRI) was used, previously translated and tested in the Spanish context by Pérez-Albéniz, de Paúl, Etxebarría, and Montes y Torres (70). The Spanish version of the instrument was validated for Argentina by TEA Ediciones (alpha = 0.89 for this sample).

Data analysis

The data were processed using the statistical package *SPSS 22* and were evaluated in a queue. An evaluation of the normality of the sample was also carried out. From the values obtained through the KS test, an asymmetric distribution was assumed for the scores of the three instruments. Consequently, nonparametric statistics were used to carry out the analysis, that is, tests using the Mann-Whittney *U* or the Kruskall-Wallis *H* analysis to compare, as appropriate, and Spearman's *Rho* coefficient to correlate. In addition, the Bonferroni correction was applied for multiple analysis where appropriate, as well as the estimation of the effect of magnitude using Cohen's coefficient *d*. The level of reliability of the scales was assessed using Cronbach's Alpha (all higher than .70).

Results

The sample was divided into two groups based on seniority in the practice of energy healing following the cutoff point: Initiates, n = 119; "Less than 2 years," + "3 to 5 years," + "6 to 10 years"; and Practitioners, n = 71:

"Between 11 and 20 years" + "More than 20 years," in order to compare both groups.

It was predicted that Practitioners would score higher compared to the Newly Initiated in (H1) positive schizotypy (confirmed, p <.001; $\underline{e}_s$ = .58), and also in their two "Positive" factors (p <.013, e_s =. 38) and "Negative" (p <.001, $\underline{e}_s$ = .39), as well as in (H5) cognitive and affective empathy (confirmed, both p <.001; $\underline{e}_s$ = .62). After a Bonferroni correction, Cognitive Disorganization and Impulsive Disconformity of the O-LIFE, and Cognitive and Affective Empathy of the TECA, were still significant (see Table 1).

A correlation was carried out using the Spearman *Rho* coefficient (r_s) between the frequency of sensory modalities in healing practices (and their total score) and the measures of Schizotypy and Empathy. A positive and significant correlation was predicted between the frequency of sensory modalities of healing practices with (H1) Schizotypy (confirmed, p < .001; including Positive and Negative, both p < .001), and (H5) Empathy (confirmed, p = .02; including the Cognitive p = .007, but not the Affective), see Table 2).

The standard means of the available samples of some of the instruments administered in other previous studies were used, in particular the TECA and the O-LIFE. An exploratory analysis using the student's t-test as a sample found significant differences for healers among the averages in positive schizotypy (p_{dif} <.001, e_s = .93), negative schizotypy (p_{dif} < .001, e_s = .27) and the total score of the O-LIFE (p_{dif} < .001, e_s = .51), and Cognitive Empathy (p_{dif} < .001, e_s = .34) and Affective Empathy (p_{dif} = .01, e_s = .21), but not in the total TECA scores. After a Bonferroni correction, Empathy (cognitive, but not affective) and Schizotypy (both Negative and Positive), were still significant (see Table 3).

A correlation was made, using Spearman's *Rho* coefficient, between the Sensory Modality of Schizotypy Healing, and Empathy with a degree of Spirituality, Hourly load (of practice), and Age. It was found that the spirituality score correlated positively and significantly with Empathy (r_s = 54, p <.001), but negatively with Schizotypy (r_s = – 30, p <.001); Hourly load (in hours) correlated positively and significantly with Sensory Modality (r_s = .34, p <.001) and Empathy (r_s = 40, p < .001), but negatively with Schizotypy (r_s = – 14, p <.04) and Empathy (r_s = 22, p <.001), and also negatively with Schizotypy alone (r_s = – 32, p <.001; see Table 4).

The sample was splitted into two groups from the Median (cutoff = 33) on the HES–R scale following the cutoff point: Low HES–R (n = 116) and High HES–R (n = 74) to determine healers with low scores in sensory healing modalities.

The results showed that the "High HES-R" group tended to show Schizotypy (p < .001, e_s = .58), that is, Positive Schizotypy (p < .001, e_s = .66), but not Negative Schizotypy, and both cognitive and affective Empathy (both p < .001, e_s = .75). After a Bonferroni correction, Positive Schizotypy, and Empathy were still significant (see Table 5).

Discussion

The aim was to compare Newly Initiated and long-time Practitioners healers (grouped according to their length of time in practice) to confirm the main hypotheses of the study, according to which practitioners tended to show a propensity for schizotypy (more benign than dysfunctional) and empathy. Although the results of this study showed high indicators of schizotypy, however, previous studies (Parra, 2006, 2012; Parra & Espinoza Paul, 2010) had also found that schizotypy, that is, certain paranormal/spiritual experiences such as experiences of encounters with entities (Houran, 2000; Parra, 2018), is related to cognitive processes that involve fantasy and the propensity for cognitive-perceptual distortion as well. Here, although differences were found in schizotypy that favor healers with high indicators of sensory healing experiences (High HES-R), no differences were found in terms of inability to feel pleasure, some social isolation, disregard of norms, and aggressive behavior traits (Impulsive Disconformity, a factor of the negative features), but cognitive traits associated with unconventional beliefs and unusual perceptual experiences were found ("positive" schizotypy).

At the same time, although schizotypy is an attenuated form of schizophrenia, other studies (Claridge, 1997; McCreery & Claridge, 2002; Wolfradt & Watzke, 2005) have dismissed this interpretation, considering it as a set of personality traits or characteristics that represent a continuum that may include unconventional beliefs and experiences, as happens in artistic creativity and social eccentricity, which is in line with the so-called "happy schizotypy," considered to be "positive" or "benign."

Irwin (2009) suggested that a cognitive style that characterizes schizotypy as positive allows the construction of a belief system that can act as a protection mechanism, allowing individuals to accept and explain their spiritual experiences, while those who do not have such a context will be "bombarded" by bizarre and strange thoughts for which they have no explanation. Therefore, healing practitioners, although they might experience greater cognitive disorganization would probably be better protected and less vulnerable to suffering anguish thanks to ‑not despite‑ their unusual experiences. An adaptive belief system can "buffer" the potentially negative effects of certain unusual experiences through the existence, or construction, of a context in which to integrate them. It is possible for healing practitioners to find a "paranormal solution" (Rabeyron & Watt, 2009) to deal with the cognitive disorganization of anomalous experiences through a system of spiritual beliefs (Parra, 2006, 2018). The "magical thinking" of healing practitioners would be adaptively more likely to build an effective, more imaginative ‑and even creative ‑frame of reference that appropriately shapes the interoceptive experiences of their practices (i.e. see Parra, 2015).

The results of this study also demonstrated that an empathic profile seems to be a common characteristic of healing practitioners, both in terms of their ability to place themselves in the client's place (empathic understanding) and of their attention to the positive and negative emotional states of their clients, which confirms the hypothesis that those people who are capable (or skilled) enough to understand others by putting themselves in their place (cognitive empathy), and who respond emotionally to the state or emotional condition of others (emotional empathy), are more apt to intervene in a healthy manner, providing psychological and even spiritual comfort. Along these same lines, the study also confirmed previous research suggesting that spirituality has an impact on empathy (DiLalla, Hull, & Dorsey, 2004; Huber & MacDonald, 2012; Kristeller & Johnson, 2005), as a model of how spiritual experiences and healing practices are mediated by the empathic quality of the healer (Kennedy, Kanthamani, & Palmer, 1994), as well as other individuals who have had paranormal experiences (Parra, 2015b).

Many forms of sensitivity in, for example, healers, psychics/seers, and Tarot readers show evidence of high levels of emotional empathy, being absorbed in the process and the therapeutic device, "integrating" with their clients or consultants. Cognitive empathy ‑to a large extent as in psychotherapeutic practice‑ can be instrumentally useful in helping to control emotional responses, reinforcing the therapeutic alliance (Parra & Sciacca, 2017). Cognitive empathy could clearly be useful to help others and guide the client to the appropriate type of help. In sum, the ability to use cognitive and emotional empathy in an integrated manner seems vital to healing practitioners (cf. Parra, 2013).

Finally, Western medicine should consider these methods as anomalous, that is, different from diagnosis, prognosis, and biomedical treatment. In truth, the word "healing" is rarely mentioned within the medical context. However, anomalous healing experiences fit the criteria of an "exceptional healing" experience, in the sense that they are significant, unexpected, and inexplicable according to the criteria of conventional science (c.f. Brown, 2000). In addition, they sometimes contain a transcendental quality capable of changing the sense of identity and worldview of the persons involved producing a number of methodological problems.

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The author declares no conflict of interest.

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