PSYCHOLOGICAL DISORDERS: COMPARISON BETWEEN MALE AND FEMALE EXPERIENTS AND NON-EXPERIENTS OF PARANORMAL PHENOMENA

Naved Iqbal*, Mehfooz Ahmad**, Sheema Aleem*** and Divya Mudgil****

ABSTRACT
Mainstream psychology and modern science does not believe in the existence of paranormal phenomena. Some researchers believe that those who claim to have paranormal phenomena also experience psychological problems others do not agree with this view. Therefore, the aim of present study was to see whether the individuals with paranormal phenomena experiences different psychological disorders. The study comprised 115 subjects, 54 experients and 61 non-experients of paranormal phenomena. All the participants were Post Graduate students. They were selected from different departments of Jamia Millia Islamia, New Delhi. Mania scale, schizotypal personality questionnaire, dissociative experience scale, Beck anxiety inventory and Beck depression inventory were administered on the participants to study different psychological problems. ANOVA was used to analyze the obtained data. The results reveal that the experients of paranormal phenomena had reported more manic, dissociative, schizotypal, anxiety, depression as compared to non experient group.

Key Words: Paranormal, mania, dissociative, schizotypal, anxiety, depression.

INTRODUCTION
Thalbourne (2003), a psychologist and a prominent researcher in the field, defined paranormal: A phenomenon is paranormal if it refers to hypothesized processes that in principle are physically impossible and outside the realm of

* Corresponding author- Prof. Naved Iqbal, Department of Psychology, Jamia Millia Islamia, New Delhi-25, Email- navedi2005@gmail.com, Mobile- 09968069547
human or animal capabilities as presently conceived by conventional scientists... often used as a synonym for “psychic,” “parapsychological,” “attributable to psi,” or even “miraculous” (though shorn of religious overtones). (pp. 83-84)

Paranormal phenomena are studied in parapsychology. Parapsychology is a discipline that seeks to investigate the existence, causes and conditions of psychic abilities, such as telepathy, precognition clairvoyance and psychokinesis, it also studies near-death experiences, out-of-the-body experiences, crisis apparitions, retro-cognitions, reincarnation memories, ghosts and life after death and so on by trying to use the scientific method.

Given the fact that more than half of the population has had at least one paranormal experience (Ross & Joshi, 1992), it is important to understand why people have such experiences. They are sometimes considered as being associated with mental disorders and the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) provides criteria for several mental disorders accompanied by paranormal experiences. The famous psychiatrist and philosopher Karl Jaspers, in his book General Psychopathology (Jaspers, 1913/1997), stated that all claimed paranormal phenomena could really only be manifestations of psychiatric symptoms.

Those who report paranormal phenomena have been found to experience higher levels than normal of psychological symptoms (McCreery & Claridge, 1995), and those with mental disorders report unusually strong convictions about supernatural phenomena (Ekblad & Chapman, 1983; Thalbourne, 1994). Stronger beliefs in the paranormal have been associated with higher scores on schizophrenia relevant measures in the general population (Thalbourne & French, 1995; Tobacyk & Wilkinson, 1990; Windholz & Diamant, 1974). People who have been diagnosed with psychotic disorders (bipolar, brief reactive psychosis, and schizophrenia) demonstrate a high phenomenological overlap with psi related experiences.

Psychological disorders are of various types. Important among them are:

- **Mania:** The presence of which is a criterion for certain psychiatric diagnoses, is a state of abnormally elevated or irritable mood, arousal, and/or energy levels (Berrios, 2004). In a sense, it is the opposite of depression.
  
  In addition to mood disorders, individuals may exhibit manic behaviour as a result of drug intoxication (notably stimulants such as cocaine or methamphetamine), medication side effects (notably steroids), or malignancy. However, mania is most often associated with bipolar disorder, where episodes of mania may alternate with episodes of major depression. Gelder et al., (2005) suggests that it is vital that mania is predicted in the early stages because the patient becomes reluctant to comply to the treatment.
Mania varies in intensity, from mild mania (known as hypomania) to full-blown mania with psychotic features including hallucinations, delusion of grandeur, suspiciousness, catatonic behaviour, aggression, and a preoccupation with thought and schemes that may lead to self-neglect. Thalbourne (1999) found that the Manic Experience showed a pattern of relationships with the belief in the Paranormal, absence of Social Naïveté, and Psychoticism.

- **Schizotypal Personality**: According to DSM IV-TR, this disorder is not classified under specific personality disorder but instead along with schizophrenia. Characteristics are as follows:
  1. Inappropriate or constricted affect (the individual appear cold and aloof)
  2. Behaviour or appearance that is odd, eccentric, or peculiar
  3. Poor rapport with others and a tendency to social withdrawal
  4. Odd beliefs or magical thinking, influencing behaviour and inconsistent with subcultural norms
  5. Subconscious or paranoid ideas
  6. Obsessive rumination without inner resistance, often with dysmorphophobic, sexual or aggressive contents
  7. Unusual perceptual experiences including somatosensory (bodily) or other illusion, depersonalization or derealization
  8. Vague, circumstantial, metaphorical, overelaborate, or stereotyped thinking, manifested by odd speech or in other ways, without gross incoherence.

A large amount of research has indeed shown a link between schizotypy and paranormal belief and experiences (Schofield & Claridge, 2007). Cognitive disorganisation was found to moderate the association between schizotypy and subjective quality of paranormal experience, with highly cognitive disorganised participants showing a negative schizotypy/distressing experiences relationship, while cognitively organised participants showed a positive schizotypy/pleasant experiences relationship. These results were interpreted in terms of the protective mechanism of having a framework of belief in which to place paranormal experiences, a mechanism more available to cognitively organised individuals. (Schofield & Gordon, 2007).

**Dissociative Disorder**

Dissociative Disorder are defined as condition that involve disruption or breakdown of memory, awareness, identity and/or perception. The hypothesis is that symptoms can result, to the extent of interfering with person’s general functioning, when one or more of these functions are disrupted.
The four dissociative disorders listed in the DSM IV TR are as follows

- **Depersonalization Disorder**: Period of detachment from self or surrounding which may be experienced as “unreal” (lacking in control of or “outside of” self) while retaining awareness that this is only a feeling and not a reality.

- **Dissociative Amnesia**: (formerly psychogenic amnesia)-noticable impairment of recall resulting from emotional trauma.

- **Dissociative Fugue**: (formerly psychogenic fugue)-physical desertion of familiar surrounding and experience of impaired recall of the past. This may lead to confusion about actual identity and the assumption of a new identity.

- **Dissociative identity disorder**: (formerly multiple personality disorder)- The alternation of the two or more distinct personality states which impaired recall, among personality states, of important information.

Experients were found to show higher levels of disassociating, absorption, paranormal belief, paranormal experience, self-reported psychic ability, fantasy proneness, tendency to hallucinate, and self-reported incidence of sleep paralysis. (French, 2008). The 9 individuals who reported prior out-of-body experiences, relative to those 31 who did not, exhibited significantly greater self-reported dissociative alterations in body-image during the mirror-gazing task, even when the influence of scores on New Age belief was controlled for statistically. The same differential relationship was not found between 6 individuals who did and 34 who did not report out-of-body experiences during the task. (Terhune, 2006).

**Anxiety**

Anxiety has become central for psychology at least since Freud. He considered anxiety as “uniquely unpleasant feeling state, accompanied by certain specific effenter phenomena and the perception thereof” (Freud, 1936, p.70). Thus according to him anxiety combines a strongly negative emotional state (such as fear, worry, uneasiness) with somatic symptoms (such as heart palpitations, fatigue, nausea, chest pain, shortness of breath, stomach aches, or headaches), and cognitive representations of that state, involving the perception of the emotional and somatic state and experiencing it consciously. *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (DSM IV-TR), anxiety disorders include generalized anxiety disorder (GAD), social anxiety disorder (also known as social phobia), specific phobia, panic disorder with and without agoraphobia, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), anxiety secondary to medical condition, acute stress disorder (ASD), and substance-induced anxiety disorder.

*Vol. 9, No. 1, September, 2014*
This researcher tested the hypotheses. Contrary to predictions, they found that belief in the paranormal experiences were not associated with a lessening of death anxiety. Houran (1997). Contrary to hypotheses, neither full Paranormal Belief Scale nor any of 7 paranormal subscale scores showed significant correlations with Trait Anxiety scale scores. Findings support the notion that paranormal beliefs are not associated with less adequate adjustment. Psychological Reports (1982). In a study of psychological impact of telepathic experiences, Stevenson (1970) found the most common emotional responses were anxiety and depression. More generally, the most commonly reported emotions are anxiety and happiness (Irwin, 1999; Milton, 1992).

**Depression**

Depression is a state of low mood and aversion to activity that can affect a person’s thoughts, behaviour, feelings and sense of well-being (Salmans, 1997). Depressed people can feel sad, anxious, empty, hopeless, worried, helpless, worthless, guilty, irritable, hurt, or restless. They may lose interest in activities that once were pleasurable, experience loss of appetite or overeating, have problems concentrating, remembering details, or making decisions, and may contemplate, attempt, or commit suicide, insomnia, excessive sleeping, fatigue, loss of energy, or aches, pains, or digestive problems may also be present (NIMH, 2012). ADHD, dissociation, and depression were associated with enhanced tendencies toward paranormal and cryptozoological beliefs, although participants who believed in each of the phenomena differed from one another in predictable and psychologically distinguishable ways (Matthew et al, 2006). Analysis showed significantly higher depressive attributional styles among high scorers on paranormal phenomena than low scorers (Dudley & Whisnand, 2000).

**Rationale**

Given the fact that more than half of the population has had at least one paranormal experience (Ross & Joshi, 1992), it is important to understand why people have such experiences. They are sometimes considered as being associated with mental disorders. This association was confirmed by several studies showing a correlation between paranormal beliefs and magical ideation (Eckbald & Chapman, 1983; Tobacyk & Wilkinson, 1990), hypomania and schizophrenia (Windholz & Diamant, 1974), manic depressiveness (Thalbourne & French, 1995) and negative relation with psychological adjustment (Irwin, 1991). On the other hand, some research has suggested that there is no link between paranormal experiences and mental health disorders (Goulding, 2004). Therefore, present study was an effort to explore the psyche of those people who have paranormal experiences in terms of certain psychological problems and compare them with those who do not have such experiences.
METHODS

Participants

Total participants of the present study comprised 115 subjects, 54 experiends and 61 non-experiends of paranormal phenomenon. There were 26 males and 28 females in experiends group. There were 31 males and 30 females in non-experiends group. All the participants were Post Graduate students. The age ranged from 20-24 years. They were selected from different departments of Social Science faculty such as Political science, Psychology, Economics and Sociology of Jamia Millia Islamia, New Delhi.

Tools

Goldberg’s Mania Scale: This scale consists of 18 items developed by pioneering researcher Dr Ivan K Goldberg (1993). It is a brief self-report questionnaire designed to identify the patients with mania psychopathology. Contents for the scale’s 18 items were garnered from extensive interviews with dissociative patients and consultation with clinical experts. In this scale there are 18 questions which were used to rate mania. On the basis of answers to these questions, the investigator could rate person on mania. The response categories of the scale are:

1. Not at all
2. Just a little
3. Some What
4. Moderately
5. Quite a lot
6. Very Much

Schizotypal Personality Questionnaire: The SPQ-B (Raine and Benishay, 1995) is a 22 item dichotomous (yes/no) questionnaire derived from the larger SPQ questionnaire (Raine, 1991). The 22 items in the new SPQ-B scale, each question answered affirmatively receives a score of 1, so that scores can range from a minimum of 0 to a maximum of 22.

Dissociative Experience Scale: This scale was developed by Carlson & Putman (1995). It is a brief self-report questionnaire designed to identify patients with dissociative psychopathology and to provide a means of qualifying experiences. The scale tape a broad range of dissociativ experiences including disturbances in memory, identity and cognition, feeling of derealization, depersonalization, absorbtion an imaginative involvement. The DES II uses a more convenient 11 point Likert Scale. The Response are ranging from never to always. Total scores are obtained by averaging the item scores. The weighted means of the test-retest and internal consistency reliabilities from these studies are .85 and .93 respectively.

Beck Anxiety Inventory: This inventory was developed by Beck, Epstein, Brown, & Steer (1988). BAI is a 21-question multiple-choice self-report inventory
that is used for measuring the severity of an individual’s anxiety. How the subject has been feeling in the last week, expressed as common symptoms of anxiety (such as numbness, hot and cold sweats, or feelings of dread). Each question has the same set of four possible answer choices, which are arranged in columns and are answered by marking the appropriate one with a cross. The response categories are as follows:

1. Not At All
2. Mildly but it didn’t bother me much.
3. Moderately – it wasn’t pleasant at times
4. Severely – it bothered me a lot

**Beck Depression Inventory:** Depression was measured by Beck Depression Inventory developed by Beck, Steer, & Brown, (1996). BDI-II contains 21 questions, each answer being scored on a scale value of 0 to 3. The test was also shown to have a high one-week test–retest reliability (Pearson r = 0.93), suggesting that it was not overly sensitive to daily variations in mood. The test also has high internal consistency (α = .91).

**Procedure**

The experients of paranormal phenomena were identified with the help of interview schedule. It had six question which were based on different paranormal abilities i.e. precognition, telepathy, clairyoyance and PK. Those who responded positively on at least two questions were considered as experients. After the informed consent had been taken the students were asked to fill the questionnaire. Before handing over the questionnaire to them, they were briefed about it and were asked to mark the answers as suited to them. Obtained data were analyzed with the help of ANOVA.

**RESULTS**

The obtained results are presented in the following tables.

**TABLE 1**

<table>
<thead>
<tr>
<th>gender</th>
<th>Types of Experients</th>
<th>Mean of Mania</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experients</td>
<td>Non-experients</td>
</tr>
<tr>
<td>Males</td>
<td>44.46</td>
<td>34.42</td>
</tr>
<tr>
<td>Females</td>
<td>34.46</td>
<td>26.47</td>
</tr>
<tr>
<td>Total Mean</td>
<td>39.28</td>
<td>30.51</td>
</tr>
</tbody>
</table>

Table 2 revealed significant F-ratios for type of experients and gender on mania at .01 levels. However, Interaction effect was not found to be significant at .05 levels. Table-1 showed that experients of paranormal scored higher than non-experients and male scored higher than females on Mania.
**TABLE 2**
Showing ANOVA Summary for Mania

<table>
<thead>
<tr>
<th>Source</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
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<td>2328.403</td>
<td>14.782</td>
<td>.000</td>
</tr>
<tr>
<td>Gender</td>
<td>1</td>
<td>2305.264</td>
<td>14.635</td>
<td>.000</td>
</tr>
<tr>
<td>Type * Gender</td>
<td>1</td>
<td>1129.909</td>
<td>.190</td>
<td>.664</td>
</tr>
<tr>
<td>Error</td>
<td>111</td>
<td>157.517</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>115</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>114</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 3**
Showing Means of different Groups on Schizotypal Personality

<table>
<thead>
<tr>
<th>Gender</th>
<th>Types of Experients</th>
<th>Mean of Mania</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experients</td>
<td>Experients</td>
</tr>
<tr>
<td>Males</td>
<td>10.77</td>
<td>7.77</td>
</tr>
<tr>
<td>Females</td>
<td>11.61</td>
<td>6.23</td>
</tr>
<tr>
<td>Total  Mean</td>
<td>11.20</td>
<td>7.02</td>
</tr>
</tbody>
</table>

**TABLE 4**
Showing ANOVA Summary for Schizotypal Personality

<table>
<thead>
<tr>
<th>Source</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>1</td>
<td>501.102</td>
<td>21.201</td>
<td>.000</td>
</tr>
<tr>
<td>Gender</td>
<td>1</td>
<td>3.535</td>
<td>.143</td>
<td>.706</td>
</tr>
<tr>
<td>Type * Gender</td>
<td>1</td>
<td>40.486</td>
<td>1.633</td>
<td>.204</td>
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<tr>
<td>Error</td>
<td>111</td>
<td>24.794</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>115</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>114</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4 showed significant F-ratio at .01 levels for type of experients on schizotypal personality. Gender and interaction effect were not found to be significant at .05 levels. Table-3 revealed that experients group scored higher than non-experients group on schizotypal personality.

**TABLE 5**
Showing Means of different Groups on Dissociative Disorder

<table>
<thead>
<tr>
<th>Gender</th>
<th>Types of Experients</th>
<th>Mean of Mania</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experients</td>
<td>Experients</td>
</tr>
<tr>
<td>Males</td>
<td>117.73</td>
<td>100.84</td>
</tr>
<tr>
<td>Females</td>
<td>109.07</td>
<td>80.53</td>
</tr>
<tr>
<td>Total  Mean</td>
<td>113.24</td>
<td>90.85</td>
</tr>
</tbody>
</table>
Table 6 reveals significant F-ratio for type of experiences on Dissociative Experiences at .01 levels. However, gender and interaction effect were not found to be significant at .05 levels. It may be observed from Table-5 that experients group scored higher than non-experients group on this dimension.

Table 7 showed that experients group experienced more anxiety than non-experients group.

Table 8 revealed significant F-ratio at .01 levels for type of experient of paranormal phenomena. Significant differences were not found at .05 levels for gender and interaction effect. Table-7 showed that experients group experienced more anxiety than non-experients group.
Table 9
Showing Means of different Groups on Depression

<table>
<thead>
<tr>
<th>Gender</th>
<th>Types of Experiences Experiencing</th>
<th>Experiences Experiencing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td></td>
<td>18.46</td>
<td>19.50</td>
</tr>
<tr>
<td></td>
<td>15.94</td>
<td>11.60</td>
</tr>
<tr>
<td></td>
<td>17.20</td>
<td>15.55</td>
</tr>
<tr>
<td>Total Mean</td>
<td>19.00</td>
<td>13.80</td>
</tr>
</tbody>
</table>

Table 10
Showing ANOVA Summary for Depression

<table>
<thead>
<tr>
<th>Source</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
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<td>777.740</td>
<td>6.830</td>
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<tr>
<td>Gender</td>
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<td>77.775</td>
<td>.683</td>
<td>.410</td>
</tr>
<tr>
<td>Type * Gender</td>
<td>1</td>
<td>206.624</td>
<td>1.814</td>
<td>.181</td>
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<tr>
<td>Error</td>
<td>111</td>
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<tr>
<td>Corrected Total</td>
<td>114</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 10 revealed significant F-ratio at .01 levels for type of experient of paranormal phenomena. It may be seen from table-9 that experient group scored higher than non-experients group on anxiety. ANOVA summary Table also reveals that F-ratio was not significant for gender and type- gender interaction at .05 levels.

Discussions

The present study examined the relationship between paranormal experiences and several psychological disorders. Results showed (table-1 & 2) that experients of paranormal phenomena had reported more manic symptoms than non-experients group and males reported more manic symptoms than females. Similar findings has been reported by Thalbourne (1999) who found that the Manic Experience showed a pattern of relationships with the belief in the Paranormal, absence of Social relationship, and Psychoticism. Manic experiences measures of paranormal experiences correlate positively with experiences of mania, sometimes in excess. Also paranormal experience correlates significantly positively with the Hypomaniac scale of MMPI: .37 with university students and comparably with patients groups 50 (Thalbourne & Delin, 1994). The seven correlates ranged from .18 to .57 with a moderate median of .41.

Table 3 & 4 revealed that the experient group of paranormal phenomenon had reported more schizotypal symptoms than non-experient group. Other studies has also reported similar findinds. Cognitive disorganisation was found to moderate the association between schizotypy and subjective quality of paranormal experience, with highly cognitive disorganised participants showing a negative schizotypy/
distressing experiences relationship, while cognitively organised participants showed a positive schizotypy/pleasant experiences relationship. These results were interpreted in terms of the protective mechanism of having a framework of belief in which to place paranormal experiences, a mechanism more available to cognitively organised individuals. (Kerry Schofield and Gordon Claridge, 2007). Similarly, Paranormal belief was heavily associated with the cognitive-perceptual component of schizotypy (Hergovich, 2007). In their advanced study Hergovich et al (2008) confirms previous studies showing stronger relations between paranormal belief and the cognitive-perceptual component of schizotypy than to the factors ‘interpersonal’ and ‘disorganized’.

Results also indicated that the experiants group of paranormal phenomena had reported more dissociative symptoms than non-experient group. The findings could be supported by the findings of French (2008) who found that the experiants showed higher levels of dissociativitiy, absorption, paranormal belief, paranormal experience, self-reported psychic ability, fantasy proneness, tendency to hallucinate, and self-reported incidence of sleep paralysis. Similarly, the 9 individuals who reported prior out-of-body experiences, relative to those 31 who did not, exhibited significantly greater self-reported dissociative alterations in body-image during the mirror-gazing task, even when the influence of scores on New Age belief was controlled for statistically.

The same differential relationship was not found between 6 individuals who did and 34 who did not report out-of-body experiences during the task (Terhune, 2006). In another study scores on dissociation were positively correlated with those on global paranormal belief and with belief in psi, precognition, spiritualism, and extraordinary life-forms (Irwin, 1994). In the same way Zingrone and Alvarado (1994) reported that in their sample DES score were significantly higher in paranormal/spiritual experiemnts compared with non-experiments (d = .62) and higher in persons with multiple mystical experiences versus non-experints, t(50) = 3.56, p = .0001.

Results showed that the experiants of paranormal phenomena had reported more anxiety symptoms than non-experient group. Houran (1997) found that belief in the paranormal experiences were not associated with a lessening of death anxiety. Contrary to hypotheses, neither full Paranormal Belief Scale nor any of 7 paranormal subscale scores showed significant correlations with Trait Anxiety scale scores. Results indicate death anxiety, as measured by the ATDS, showed significant relations with paranormal beliefs and experiences. Present findings provide strong evidence for earlier contentions that paranormal beliefs serve a function analogous to traditional religious beliefs in reducing death anxiety (Lange & Houran 1997). They also indicated decreases in fear of death, depression or anxiety, isolation and loneliness, and worry and fears about the future. A large majority of respondents indicated that these effects resulted from
a combination of more than one paranormal and/or transcendent experience (Kennedy & Kanthamani, 1995).

Present investigation also showed that individuals who experienced paranormal phenomenon had reported more depressive symptoms than those who did not. Other studies also support the present findings. Matthew, Justin and Janet, (2006) found that the ADHD, dissociation, and depression were associated with enhanced tendencies toward paranormal and cryptozoological beliefs, although participants who believed in each of the phenomena differed from one another in predictable and psychologically distinguishable ways. Similar results were observed in the analysis, in which significantly higher depressive attributional styles among high scorers on paranormal phenomena than low scorers (Dudley et al, 2000).

CONCLUSION

In sum, experients of paranormal phenomena reported more psychological problems than non-experients of paranormal phenomena.

REFERENCES


