Philosophy, Psychiatry, & Psychology 4.1 (1997) 41-65

Spiritual Experience and Psychopathology

Mike Jackson & K. W. M. Fulford

Abstract: A recent study of the relationship between spiritual experience and psychopathology (reported in detail elsewhere) suggested that psychotic phenomena could occur in the context of spiritual experiences rather than mental illness. In the present paper, this finding is illustrated with three detailed case histories. Its implications are then explored for psychopathology, for psychiatric classification, and for our understanding of the concept of mental illness. It is argued that pathological and spiritual psychotic phenomena cannot be distinguished by 1) form and content alone (as in traditional psychopathology), 2) by their relationship either with other symptoms or with pathological causes (as in psychiatric classification), or 3) by reference to the descriptive criteria of mental illness implied by the "medical" model. The distinction is shown to depend, rather, on the way in which psychotic phenomena themselves are embedded in the values and beliefs of the person concerned. This in turn is shown to have implications for diagnosis (it shows the need for clinicians to attend to the values and beliefs of individual patients), for treatment (it points to a cognitive problem-solving model), and for research in psychopathology (especially as related to the emerging sciences of dynamic brain imaging and cognitive neuroscience).

Keywords: first rank symptoms, schizophrenia, delusion, hallucination, thought disorder, religious experience, mystical experience

Introduction

This paper explores some of the conceptual and practical implications of the finding that phenomena which in a medical context would probably be diagnosed as psychotic *symptoms*, may occur in the context of non-pathological, and indeed essentially benign, spiritual experiences.

The existence of non-pathological psychotic experiences of this kind (we will call them "psychotic *phenomena*" as distinct from "psychotic *symptoms*"--see also Endnote 1, terminology) was a key finding in a study carried out by one of us (MJ) at the Alister Hardy Research Centre (AHRC) in Oxford. Details are given elsewhere both of the overall empirical findings of the study, including the relationship between spiritual

experience and personality variables, and of a hypothetical cognitive problem-solving model of these phenomena (Jackson 1991, and forthcoming a and b). In the present paper, 1) the background to the study is described briefly in relation to earlier work on the possible links between spiritual experience and psychopathology; 2) some of the psychotic phenomena identified are illustrated with three detailed case histories; 3) the significance of these phenomena is reviewed for our understanding respectively of psychopathology, of diagnostic syndromes, and of the concept of mental illness; and 4) some of the practical implications of the study for clinical work and research in psychiatry are indicated.

Background

It has long been recognized that there are similarities between spiritual and psychotic experiences. **[End Page 41]** William James (1902), for example, argued that "in delusional insanity, paranoia as they sometimes call it, we may have a kind of diabolical mysticism, a sort of religious mysticism turned upside down" (426). Other commentators have noted a wide variety of phenomena, such as time distortion, synesthesias, loss of self-object boundaries and the transition from a state of conflict and anxiety to one of sudden "understanding," all of which are reported in both spiritual and psychotic experiences (Buckley 1981; Watson 1982; Wapnick 1969; and Wootton and Allen 1983).

Yet the similarities notwithstanding, the distinction between these two kinds of experience can be crucially important. *Spiritual* experiences, whether welcome or unwelcome, and whether or not they are psychotic in form, have nothing (directly) to do with medicine (Fulford 1996a). It would be quite wrong, then, to "treat" spiritual psychotic experiences with neuroleptic drugs, just as it is quite wrong to "treat" political dissidents as though they were ill (Fulford, Smirnoff and Snow, 1993). Pathological psychotic experiences, on the other hand, or psychotic *symptoms*, are by definition a proper object of medical treatment, sometimes even against the wishes of the person concerned. Hence it would be both negligent and, as Wing (1978) put it, morally "repellent," to leave untreated someone who is genuinely ill (244).

Given how much turns on the distinction between spiritual experience and psychopathology, it is perhaps not surprising that scholarly discussion of the relationship between them has at times been polarized and polemical. At one extreme there are those who admit no overlap (Greeley 1974; see also Deikman 1977; Wilber 1980; and Pelosi 1988); at the other extreme are those who recognize no distinction, collapsing all spiritual experience to psychopathology (Group for the Advancement of Psychiatry 1976), or all psychopathology to spiritual (though not necessarily religious) experience--this is the implication of much anti-psychiatric literature, for example (notably Laing 1967).

Between these extremes, a number of more complex views of the relationship between the two kinds of phenomena have been advanced, views which attempt to account for both the similarities and differences between them. We will be returning to some of these in more detail later in relation specifically to the findings of the present study. They are summarized in the notes and table given in Endnote 2. Part of the problem, as Proudfoot (1985) has argued, is a critical difficulty of definition. Both spiritual experience and psychopathology come in many varieties; the terms themselves are used in many different ways, and even the more restricted medical use of "psychosis" has no agreed meaning (Fulford 1989, ch. 10). It may indeed be that there is no gold standard definition,

the meanings of these terms varying accordingly to the uses to which they are put in different contexts.

The heterogeneous nature of both spiritual experience and psychopathology, and the likelihood that definitions will always have to be use-specific, raises a number of difficult methodological issues for research in this area. Within a given and well-defined field, researchers can achieve a high degree of inter-observer agreement, or reliability, as in the descriptive psychopathology of modern psychiatry (see, for example, Wing, Cooper, and Sartorius 1974). The very success of such approaches, however, has sometimes blinded researchers to the assumptions upon which their successes depend. There is growing evidence at the present time, for example, of the extent to which psychiatric categories of disorder are both culture-specific and even gender-specific, notwithstanding their claims to being "theory-free" (Radden 1994).

Rather than attempting to eliminate bias, then, the validity of research in this area depends on making the purposes and context of any given study as transparent as possible. The purpose of the study from which the cases reported here are derived was to explore difficulties arising at the interface between religion and psychiatry. The study itself is described briefly in the next section and reported fully elsewhere (Jackson 1991, and forthcoming a and b). The key methodological points, though, are 1) that the study deliberately targeted a situation in which problems at the interface between psychiatry and religion were likely to be most evident, and 2) that the experiences of those **[End Page 42]** concerned are described primarily in terms of the way they were understood by the subjects themselves and those close to them (whether professionals such as psychiatrists and priests, or friends and relatives) rather than by reference to the received categories of this or that particular discipline (whether medical or theological).

Such an approach, being highly focused, case-based and respondent sensitive, has its own limitations, of course. It is as likely to stimulate new questions (empirical, phenomenological or conceptual) as to resolve old ones. Empirically, for example, it may indeed identify problems at the psychiatry/religion interface, and it will provide relevant detail about the way such problems are experienced, but in itself it can say nothing about the overall prevalence of these problems (Jackson, forthcoming a). It is, though, the specifically *conceptual* issues raised by the findings of the study with which we are concerned here. These issues are relatively insensitive to questions of prevalence: like crucial observations in scientific research, the conceptual significance of the real experiences of real people is a function of the extent to which, whether commonplace or rare, they challenge the coherence and comprehensiveness of the received framework of ideas within which experience is structured and understood (Fulford 1990; Wilkes 1988). As in medicine, however, the case method of inquiry is most fruitful--indeed it is only worthwhile at all--if it is based on careful observations of the details of actual case histories. In the next section, then, we give a brief introductory account of the study as a whole, including the methods adopted, and then describe in detail the experiences of three of the subjects, Sean, Sara, and Simon, by whom the conceptual issues are raised in a particularly acute way.

The Study

The current study was made possible in part by the opportunity offered by the Alister Hardy Research Centre in Oxford to use their uniquely extensive data base of over five thousand contemporary accounts of spiritual experience. With access to such a large and

diverse pool of subjects, it was possible to select test cases strategically. As already emphasized, this approach was not designed to explore in a general way the relationship between spiritual experience and psychotic illness. It was intended, rather, to focus specifically on issues arising in the area of overlap between them, a key purpose of the study being to decide whether, in fact, psychotic phenomena can occur in the context of benign spiritual experiences, and if so, to explain the significance of this occurrence.

The sample. Cases were selected from the 1,000 most recent accounts received by the AHRC (covering the period 1984-1989). The selection criteria for the undiagnosed cases described here were as follows:

1. Report of a significant period of intense experience, explained in religious or paranormal terms by the respondent, and assessed as possibly involving delusions or hallucinations as defined in the Glossary to the Present State Examination (Wing, Cooper and Sartorius 1974).

2. Apparent absence of functional deficits, as indicated by lack of psychiatric involvement and evidence of positive social adjustment.

3. Geographical proximity to the research center.

In order to obtain detailed information, 15 individuals selected in this way were contacted with a request for an interview, and nine interviews were eventually conducted, of which three are reported here. One of these ("Simon") was entirely self-selected, in that he simply arrived at the Research Centre during the study.

Method. A semi-structured interview was developed, covering the participant's background and history, the context, phenomenology and effects of their spiritual experiences, and the interpretations which they and others placed on them. Tape recorded interviews were conducted in the participants' homes and subsequently transcribed. These lasted between two and four hours. The purpose of the study was explained at the start of the interview. It was made clear that the interviewer, being a representative of a research organization concerned with spiritual experience, was sympathetic to the spiritual significance for the interviewees of their experiences. **[End Page 43]**

Overview of Results

The original study (Jackson 1991) included a comparison of five subjects selected as above (the "undiagnosed group") with five who had recovered from major psychoses but nonetheless interpreted their experiences in strongly spiritual terms (the "diagnosed group"). This part of the study produced counter-examples for each of the criteria for distinguishing between spiritual experience and psychopathology proposed in the previous literature, as discussed earlier and as represented in the table in Endnote 2. Thus, only a minority of experiences reported by either group were sub-culturally influenced, and if anything, this factor was more widely observed in the diagnosed group. Undiagnosed interviewees had markedly grandiose beliefs about their own status and spiritual role; some reported experiences of both malignant and idiosyncratic spiritual entities; they lacked volitional control over their experiences (although individuals in both groups described acquiring increased control with the passage of time); they described both emotionally positive and negative experiences, true and pseudo hallucinations, and

mood congruent and mood incongruent hallucinations; visual and auditory hallucinations (indeed visual hallucinations were more commonly reported in the diagnosed group); they held "delusional" beliefs with full conviction; lacked insight into the possibility that their experiences could be explained as psychological rather than spiritual phenomena; and they described experiences which continued for extended periods of time.

Far from being phenomenologically distinct, therefore, what was perhaps most striking about the two groups was the extent of their phenomenological similarities. Even in this highly selected sample, it should be said that there were certain overall differences of degree between the experiences described by the diagnosed and undiagnosed subjects. Most strikingly, the diagnosed subjects had been totally overwhelmed by their psychoses, and had effectively lost contact with consensual reality for extended periods of time, during which they acted out their delusions in bizarre behavior. While there were some indications of this type of effect in the undiagnosed group, it was considerably less severe. In this respect, then, there was a clear sense in which the experiences described by diagnosed subjects were more "pathological" (indeed this was the selection criterion on which the separation of the two groups was based). The diagnosed group also differed in unanimously reporting intensely negative experience. While this was described by some undiagnosed subjects, it was, again, considerably less extensive. However, both groups reported positive experiences, and some diagnosed subjects felt that these compensated for their more negative experiences.

In summary, then, the experiences described in both groups involved broadly similar phenomena, but these tended to be more negative and overwhelming in the diagnosed subjects. None of the differences were decisive, though, and the question remains whether in an individual case the distinction between spiritual experience and psychopathology can be made solely in terms of traditional diagnostic methods as set out in standard psychiatric texts. We return to this question after describing three cases in detail.

Cases. In the following, anonymized case material is presented and discussed in terms of the themes raised above. In particular, the symptomatology of reported experiences is assessed by reference to the diagnostic criteria defined in traditional descriptive psychopathology, drawing especially on one of the most widely used standardized diagnostic tools, the PSE (Wing, Cooper and Sartorius 1974).

1. Simon

Simon (40) was a senior black American professional from a middle-class Baptist family. Before the main period of his spiritual experiences, he reported sporadic, relatively unremarkable, psychic experiences. These had led him to seek the guidance of a professional "seer," with whom he occasionally consulted on major life events and decisions.

Around four years before the first interview, his hitherto successful career was threatened by legal action from his colleagues. Although he claimed to be innocent, mounting a defense would be expensive and hazardous. He responded to **[End Page 44]** this crisis by praying at a small altar which he set up in his front room. After an emotional evening's "outpouring," he discovered that the candle wax had left a "seal" (or "sun") on several consecutive pages of his Bible, covering certain letters and words. He described his experiences thus. "*I got up and I saw the seal that was in my father's Bible and I called X*

and I said, 'You know, something remarkable is going on over here.' I think the beauty of it was the specificity by which the sun burned through. It was . . . in my mind, a clever play on words." Although the marked words and letters had no explicit meaning, Simon interpreted this event as a direct communication from God, which signified that he had a special purpose or mission. This belief meets the PSE definition of a *Primary Delusion*, in that it was "based on sensory experiences," and involved him "suddenly becoming convinced that a particular set of events had a special meaning" (PSE symptom 82). [1]

From this time on, Simon received a complex series of "revelations" largely conveyed through the images left in melted candle wax. He carried photos of these, which left most observers unimpressed, but were, for him, clearly representations of biblical symbols, particularly from the book of Revelations (the bull, the twenty-four elders, the ark of the covenant, etc.). His interpretations of them, moreover, would be consistent with *Delusions of Grandiose Ability* (PSE symptom 76): they signified that "*I am the living son of David . . . and I'm also a relative of Ishmael, and . . . of Joseph."* He was also the *"captain of the guard of Israel."* He found this role carried awesome responsibilities: "*Sometimes I'm saying--O my God, why did you choose me, and there's no answer to that."* His special status had the effect of "*Increasing my own inward sense, wisdom, understanding, and endurance"* which would "*allow me to do whatever is required in terms of bringing whatever message it is that God wants me to bring."*

The PSE (symptom 78) defines *Religious Delusions* as "both a religious identification on the part of a subject and an explanation in religious terms of other abnormal experiences." This clearly applies to Simon's central beliefs, which he expressed with full conviction "*The truths that are up in that room are the truths that have been spoken of for 4,000 years."* When confronted with skepticism, he commented: *"I don't get upset, because I know within myself, what I know."*

His central belief was highly systematized, in that he interpreted much of his ongoing experience in terms of it. His colleagues were agents of Satan, trying to thwart him, and his career successes were evidence of God's special favor. Relatively trivial obstacles which he encountered in daily life--such as having a cold at the time of the interview--were satanically motivated trials of purpose.

He also described experiences of *Inserted Thoughts* (PSE symptom 55), using the following evocative simile: "*If you're sitting and watching television, and then somebody turns on the vacuum cleaner, and the TV goes on the fritz, it's like that"/"the things that come are not the things that I have been thinking about. . . . They kind of short circuit the brain, and bring their message."* In the course of these experiences he had both heard God's voice and seen "prophetic" visions.

Simon had no *insight,* in the sense (defined in the PSE, symptom 104) that he considered his mental processes to be completely normal. He had told various friends and ministers about them, and believed that "*No one really thought I was crazy because . . . they've known me all my life . . . and I think God would not permit it, to be honest with you."* However, he was careful to conceal what was happening from his colleagues, as he recognized that they would perceive it as suspect.

While his beliefs were clearly sub-culturally influenced, they were "further elaborated . . . so that other members of the sub-group might well recognize them as abnormal" (PSE symptom 83: *Sub-culturally influenced delusions*). Indeed, Simon was puzzled by the

way in which certain of the ministers he had consulted drew attention to their messianic overtones. He had "*stopped talking to some of the ministers"* and he commented that "*people want to take it away from me, and say 'I'm glad that you don't see it as something especially for you.' . . . They'll try and dismiss me out of the equation, which I find fascinating."* **[End Page 45]**

Diagnostically, Simon's experiences, if assumed to be pathological, might suggest schizophrenia (on the basis of thought insertion and a primary delusion). Alternatively, the presence of a well systematized set of delusions, in the absence of prominent hallucinations, might suggest a DSM-IIIR diagnosis of delusional disorder. However, as far as Simon was concerned, his revelations had been entirely beneficial in his life. He claimed that they gave him the conviction to contest and win the lawsuit against him, and more generally to succeed as a high-achieving black person in a predominantly white, racist context. He had high self-esteem, firm moral convictions, and a strong sense of purpose in life. His beliefs then, whilst unusual in content, and psychotic in form, were essentially affirming, and if anything increased rather that detracted from his ability to function effectively.

A year after the initial interview he made contact again. He reported that in the interval his career had flourished and that he had successfully set up a new charitably oriented institution. His revelations had continued; indeed they had increased in frequency and scope. He confided that his mission involved unifying "true Christianity" (a "*return to the ancient ways of the worship of the Lord")* and "true Islam." He had plans to announce himself live on TV but was waiting for the right signs.

2. Sara

Sara (aged 43) was a pastoral worker from a middle-class, Christian family. She had trained as a secretary and worked for a large industrial company. In her early thirties, she went through a period of untreated depression after discovering that she could not have children. This abated when she received accelerated promotion into middle management. Her initial experience occurred at a time when she was beginning to question her level of commitment to her career. She was waiting at a traffic light on her way to work, when "*I heard a voice say 'Sara, this is Jesus. When are you coming to work for me?' And my first reaction was, I honestly thought it was my brother hidden in the back of the car. . . . I thought he was having me on. I turned round to look and there was nobody there. I turned back and thought 'He's put a tape in the car' because it was so real and there was nothing there. Then I heard it again . . . I knew beyond any shadow of a doubt who it was and I also thought to myself "You must be joking. I'm not giving up my management career. On your bike, sunshine! No way.'"*

In the PSE this would be classified as a psychotic or *True Hallucination* because the voice is experienced as coming from outside the mind (PSE symptom 65). Moreover, consistently with a diagnosis of schizophrenia, it is not affectively bound (i.e., the content is not a direct reflection of the subject's mood) and it is in the first person (i.e., it is addressing the subject). For Sara this occurrence marked the beginning of a sequence of frequent experiences of "*God's voice*," giving her detailed instructions and information: for example, in a library she heard "*fourth shelf down, third book along, page 170."* She had compiled these experiences into a book on the workings of the kingdom of heaven.

Over the four years between the onset of her experiences and the interview, the "voice"

became increasingly internal and less prominent: "*In the first five months it was ultra clear because I couldn't hear anything else, but God doesn't take your free will away. . . . It was just that he'd turned his own volume up, if you like. When you equalize the volumes I can listen to Him or I can do my own thing. Most of the time I'm clear but not always."* At the time of the interview, she still heard "*that little voice*" but had learned to distinguish it reliably from "*outside voices*": "*There is total inner stillness, inner peace and silence and it's as if there's something inside me, but that's where it communicates and moves. I can feel it. I can't explain it but I can feel it."*

Sara believed that through God's intervention she had acquired various paranormal capabilities. The dominant paranormal element in her subsequent experiences was synchronicity: "*the co-ordinating . . . at the right time in life, the right books, the right references and the right people and the right courses. The information being given to me."* She also described numerous experiences involving telepathy, precognition, healing and communication with the dead, together with corroborating evidence. These often involved visual **[End Page 46]** imagery which she described as "*picture language inside me."* She interpreted her experiences as a divine calling: "*For some reason I have been asked to be a specialist in this and I know an awful lot more than many people and priests come and talk to me about it and other people in that field."* According to the PSE, these beliefs involve *Delusions of Grandiose Ability* (symptom 76, "subject thinks he is chosen by some power . . . for a special mission or purpose, because of his unusual talents. He thinks he is able to read people's thoughts. . . ."): and *Religious Delusions* (symptom 78, as described above for Simon). They were expressed with full conviction (she "knew" rather than believed), and she claimed to be unconcerned about skeptical interpretations: *"You can't convince people unless they want to look. I don't care if they are skeptical."*

The onset of these experiences precipitated a period of intense conflict for Sara, during which she was "*terrified of going mad,"* and eventually sought the counsel of her minister. "*He thought I was having a religious wobbler at first and said 'Don't give up your management career.' But he gradually realized that it wasn't, it was something solid, not a schizophrenic breakdown."* He gave her a number of well-grounded reasons why he decided that her experiences were authentic: "*I was behaving rationally, coping with my job, making decisions, talking to my husband about the fact that I needed to leave work . . . making sensible arrangements about changing my life, and because I wasn't showing any phobias, paranoia's or whatever."*

From her perspective, and apparently that of her priest, Sara's experiences were firmly embedded in mainstream Christian (Anglican) doctrine. However, other cases in the AHRC archive describe considerably less open-minded responses from clergy to less unusual experiences, including, in some cases, the suggestion that the confidant was in need of psychiatric help. As we discuss in the concluding section of this paper, it is interesting to speculate how Sara's experiences would have developed had she met with a less validating response from her priest.

At the time of the interview Sara was living a fulfilling and altruistic life. This involved working as a counselor and as a spiritual director to Anglican priests. As a member of the university chaplaincy pastoral team, she was also running a prayer group. Her experiences, if delusional and hallucinatory, were overwhelmingly positive in their content and fruits: "*It has always enhanced my life; it's brought a great deal to other people and it is benign; it is co-operative; it is loving; it helps me see the beauty of nature; hear the*

beauty of music; understand myself and others; reach out to others; begin to grasp something about ultimate reality and the way the universe is. It never torments me or taunts me; it teases me lovingly sometimes. . . . If I'm mad, so be it, but this is the most real thing I've ever known."

3. Sean

Sean was a 53-year-old life insurance salesman from a middle class background. He had a "very basic" education in a secondary modern school. Apart from a brief period of involvement with an evangelical Christian group in his youth, he had been a "militant atheist" for most of his life until the onset of his spiritual experiences.

At the time, he was in a financial crisis due to unemployment, and strongly suspected that he had multiple sclerosis. He was "worried sick" about this as he walked his dog through some local fields, when he "*heard words not of my choice, but like another voice within me saying my name--'Sean, none of this matters, you will always have what you need.'"* The voice then "instructed" him about the ephemeral nature of mundane reality and the need for an attitude of acceptance rather than resistance towards events. When he reached the road, "*my own thoughts started to come back"* and "*all the worry lifted."*

This and other voices continued to speak to Sean at length *"almost daily"* for about nine months, and then less frequently, on subjects related to the nature of the cosmic order and the practical consequences of this for him. He was clear that it was an internal voice, *"like coming through a headset."* But he was equally certain that it was not his own voice: *"it was not my voice, not my sound of voice. . . . Everything was so simply said and yet directly to the point. The meaning was there with few words and . . . not* **[End Page 47]** *clever words but a phraseology that I wouldn't normally use."* He gave a number of examples of what he had heard, for example: *"This is the beginning of things. Have no worries because . . . you are living in a timed existence now. That will pass, and this is the beginning of eternity. . . . We are all part of one another. Our intelligence is all linked."* He believed his communicants (who referred to themselves as "we") were from a "higher" level of the cosmic hierarchy. He referred to them as the CIA (Central Intelligence Agency). He believed that they knew a lot about subjects he had no opinions on and could answer questions that he put to them. This included confirming that he did indeed have multiple sclerosis, while reassuring him that he would still be able to function sufficiently well for his needs.

Sean's experiences, understood as psychopathology, fall somewhere between *Thought Insertion* (PSE symptom 55) and *Auditory Pseudohallucinations* (PSE symptom 65). The PSE defines thought insertion as follows: "the essence of the symptom is that the subject experiences thoughts *which are not his own* intruding into his mind" (emphasis in original). It notes that "auditory pseudohallucinations (voices experienced as being within the mind) may be very difficult to distinguish (from thought insertion), since sometimes the subject is unable to say whether the experience is a voice or a thought. In such cases rate both symptoms as present." This would apply to Sean, who described his experiences as both voices and thoughts. Initially, these were involuntary and uninvited, but he quickly began to seek them out, returning to the same site, and looking for *"contact*."

In his original letter to the AHRC, Sean wrote: *"It is fascinating to find I'm not on my own in this. I have naturally queried my own sanity, and generally don't discuss it. . . . When I*

saw that article . . . it was not only interesting but a great relief to find I'm not cracking up after all!" In the interview he said: "*I know me, I ain't no loony, I don't go and do crazy things. I lead a perfectly normal, respectable type of life, not because I have to but because it suits me. . . . I am definitely sure . . . that I am open to hear things that most people aren't."* Finally, he said that he did not feel that a doctor would be competent to judge whether his experiences were real, although he would be worried about other people's reactions to a doctor's opinion. *"I just simply don't want anyone to know I'm a loony if I am."*

As far as he was concerned, his experiences were completely separate from his cultural background. Although they involved universal religious themes, the only religion he had encountered previously was relatively fundamentalist Christianity, which he regarded as irrelevant to his experiences. He had never discussed his experience with anyone before the interview except, briefly, with his wife. She thought he was joking and he didn't raise the subject again.

Sean was emphatic that his experiences had a profound and entirely positive effect in his life. When they started, he was in a state of hopeless despair, and the voice marked a turning point for him. *"It turned me upside down in many ways. It altered my views completely. . . . [I] live life now as far as I can by what I'm learning."* He felt that it had helped him to cope with his difficulties, including multiple sclerosis, in an effective but effortless and relaxed way. *"I think I have support and guidance, so nothing in this world can worry me."* At the time of the interview, he no longer heard the voices in the same concrete way, although he still felt that he was *"guided*."

Overview of cases. Collectively, these cases involve a number of psychotic phenomena, including a primary delusion (Simon), religious delusions (Simon and Sara), delusions of grandiose ability (Simon and Sara), thought insertion (Simon and Sean), auditory pseudohallucination (Sean), and auditory hallucinations (Sara and Sean). These phenomena, however, occurred in the context of experiences which, *prima facie*, were not pathological. On the contrary, the experiences were of a kind which appeared to the subjects themselves and to others to be spiritual in nature and benign in their effects.

Discussion

In this section we consider the significance of the findings illustrated by the above three cases for our understanding of i) psychopathology (the symptoms of illness), ii) nosology (disease classification), **[End Page 48]** and iii) the concept of mental illness (in particular the relationship between spiritual and pathological varieties of psychotic experience). The discussion draws broadly on a framework of ideas on the conceptual structure of medicine and psychiatry set out by one of us in detail elsewhere (Fulford 1989).

1. Psychopathology

Traditional psychopathology, as we saw in the introductory section, defines the symptoms of mental illness in terms of their form and content (Jaspers 1913; Sims 1988). Broadly speaking, form is more significant diagnostically than content. A delusion of guilt, for example, may point to a diagnosis of depression. But the symptom is marked out *as* a symptom (i.e., as a delusional rather than normal belief that one is guilty) by its form.

Some formal features are general to all pathology: duration and intensity, for example, are features as much of physical symptoms, such as pains, as of mental (Fulford 1989, ch. 7; Lockyer 1981). Other features are more specific. Thus delusion is generally defined as a belief which is incorrigible and not sanctioned culturally; most definitions add that it is a false (e.g., Harré and Lamb 1987), or at any rate unfounded (e.g., Gelder, Gath and Mayou 1989) belief. Hallucinations, similarly, are perceptions occurring in the absence of a stimulus, and thought insertion is the experience of some other agency's thoughts being inserted into one's own mind. For experiences of these kinds to be genuinely psychotic symptoms, moreover, traditional psychopathology requires that the patient shows a "lack of insight" into their psychological origin: with genuinely psychotic delusions of guilt, for example, the problem from the patient's perspective is not that there is something psychologically wrong with him (usually that he is depressed), but that, straightforwardly, he has done something wrong; with auditory hallucinations, similarly, it is not that she is "hearing voices," but that, again straightforwardly, that someone is speaking to (or about) her.

The experiences reported by the subjects in the above study are consistent with these broad brush features of the form of psychotic symptoms. In the first place, the phenomena were certainly intense and enduring. In each case the experiences occurred over an extended period, although there were indications in some cases that they could become less intense with time (Sara and Sean). The beliefs of all the subjects were incorrigible--expressed as certain knowledge, rather than as beliefs open to doubt. Sara and Sean had some initial doubts about the authenticity of their experiences but soon came to believe in them implicitly. Simon was convinced right from the start. Similarly, while there was some variation in how far their experiences were sanctioned or influenced by their sub-cultural context, all were at least atypical: Sara's beliefs were largely orthodox; but her priest considered that her experiences, although authentic, were certainly unusual. Simon's experiences were clearly influenced by his reading of the Book of Revelation. He reported mixed responses, however, from clergy he had consulted, including some criticism of the messianic aspects of his beliefs. For Sean, his experiences were not related to religion, of which indeed he had little or no experience. He had no links with any sympathetic sub-cultural group, and apart from his contact with the AHRC, and one attempt to talk to his wife, he kept his experiences entirely to himself.

None of the interviewees, furthermore, could be said to have retained insight, in the sense (adopted in traditional psychopathology) of accepting the possibility that there might have been an internal psychological, rather than external spiritual, cause of their experiences. Sara and Sean had been through an initial period of worrying that they were going mad at the onset of their major periods of spiritual experience. By the time of interview, however, they firmly rejected this possibility and believed with full conviction that the sources of their experiences were external, rather than in any sense psychological. Simon denied ever having thought of his experiences as possibly insane, or other than what he believed them to be.

All three subjects, it is true, exhibited a kind of "secondary insight" towards their experiences, in the sense that they recognized that others might see them as being bizarre or mad. They were **[End Page 49]** appropriately selective about who they confided in, and had not previously described their experiences in such detail before the interviews. This degree of caution may have protected them from stigmatization or other adverse social consequences, although it was more clearly in place for some than others. Sean, for example, had never confided in anyone before the interview; Simon had plans

to announce himself on national TV, but only when the time was ripe. Secondary insight of this kind, it should be added, is commonly shown by patients with unequivocally psychotic symptoms. Its appearance in these subjects thus strengthens rather than weakens the similarities between their experiences and those of patients with psychotic illnesses.

Overall, then, the psychotic phenomena reported by our subjects were closely similar in their general formal characteristics to psychotic symptoms as defined by traditional psychopathology. Psychopathology, though, is concerned also with particular symptoms, with the particular symptoms by which schizophrenia, for example, is defined. Here content as well as form may be important. We have already seen that the content of different delusional beliefs may point empirically to particular diagnoses (e.g., delusions of guilt point to depression, as above). Another example is first person auditory hallucinations (voices addressing the patient). Occurring in clear consciousness, these are pathognomonic of schizophrenia if the content of what is said is mood incongruent, i.e., not driven by the patient's predominant mood (patients with depression may hear voices criticizing them, for instance).

As defined by the *content* of their experiences, the subjects in the present study reported only a subset of the psychotic phenomena regarded as symptoms by traditional psychopathology. In part, this may reflect the selection criteria. Some symptoms (delusions of persecution, for instance) are by their nature *malign* and hence unlikely to figure in *benign* spiritual (or any other non-pathological) experiences (we return to the question of how psychotic experiences are evaluated below). Also, the study was designed to examine a small number of subjects in depth. It is an empirical question whether other psychotic phenomena traditionally regarded as symptoms would figure in a larger series. Either way, though, some revision of our understanding of traditional psychopathology is required. For if *any* subset of the phenomena traditionally regarded as psychotic symptoms can be shown to occur sometimes in the context of healthy and adaptive (including spiritual), rather than pathological and maladaptive experiences, then either we delete the phenomena in question from our psychopathology (on the grounds that these phenomena can no longer be regarded as unambiguously pathological), or we recognize that pathology itself must be defined other than by reference solely to the form and content of particular experiences. The first option raises the general question of the validity of the concept of mental illness. We return to this shortly. The second option takes us from traditional psychopathology to nosology.

2. Nosology

Psychiatric diagnosis can be thought of as a two stage process involving, first, the identification of symptoms and, second, the attribution of those symptoms to particular disease categories. The latter are defined, in most cases, not by particular symptoms but by *groups* of symptoms (or "syndromes") and/or *associations* with particular causes and/or consequences (Fulford 1989, ch. 4). The differences between psychotic and spiritual experiences may thus be thought to lie, not in this or that particular symptom, but in patterns of symptoms or their causes or consequences.

Applying this approach to the cases reported here raises a number of difficulties. In the first place, as far as syndromes (groups of symptoms) are concerned, diseases *may* be defined by single symptoms. Even in physical medicine, migraine, for example, means essentially a recurring unilateral headache (although it is commonly associated with other

signs and symptoms). In psychiatry, there is a whole class of "monosymptomatic delusional disorders," such as morbid jealousy (Shepherd 1961). Moreover, among the psychotic experiences reported by the subjects in this study, at least two have traditionally been regarded as pathognomonic of schizophrenia: mood incongruent first-person auditory hallucinations (see **[End Page 50]** above) and thought insertion (occurring in clear consciousness, i.e., in the absence of memory loss, confusion, etc.). Just one symptom of this kind is sufficient, in traditional systems of classification, for a diagnosis of schizophrenia (e.g. in Schneider 1959; see also the material below on diagnostic categories and the consequences of disorder in the DSM.)

The causes of an experience at first sight look more promising as a basis for differentiating spiritual from pathological forms of psychotic experience. Much of diagnosis in physical medicine, after all, is concerned with tests for aetiological agents (such as bacteria), underlying pathological changes in the body (e.g. anemia), and so forth. And there is a common presumption, among doctors at least, that the *mere* demonstration of a bodily cause for an experience or behavior is, in itself, sufficient to show that the experience or behavior is pathological. This is especially so in the case of the "mad/bad" distinction in forensic psychiatry (Fulford 1991).

Again, though, there are difficulties. There is the general logical difficulty, that an *X* cannot be defined in terms of the *causes* of X. Then again, it is clearly *not* the case that the *mere* demonstration of the bodily causes of an experience is enough to show it to be pathological. After all, *any* experience, including any paranormal experience, must be brain-based at some point. In the case of pathology, moreover, there is a good case to be made for the view that bodily changes in structure or functioning are marked out (logically) *as* pathology by their tendency to cause illness experiences, rather than vice versa: in other words, disease (including causally defined disease categories) is defined by illness rather than illness by disease (Fulford 1989, ch. 4; also further comments in Endnote 3). At all events, in the case of spiritual and psychotic experiences, we simply do not at present have the causal theories required to distinguish between them in this way. Hence whatever might or might not be possible in the future, we cannot for the moment rely on the causes of these experiences as a basis for distinguishing the healthy ones from the pathological.

What about the consequences of the experiences then? Here again, we may seem at first glance to be on firmer ground. Consequences *can* at least be assessed, no underlying causal theory being required. And the approach *is* plausible. The very *raison d'être* of the present study, after all, was that the experiences of the subjects concerned were benign in the sense that unlike psychotic illnesses such as schizophrenia, their effects were highly beneficial. Moreover, the relevance of this is reflected in at least some classifications of mental disorders. In both the DSM III-R and DSM IV (American Psychiatric Association 1987 and 1994), for instance, though not in the earlier DSM III (American Psychiatric Association 1980) or the current ICD 10 (World Health Organization 1992), a diagnosis of schizophrenia requires, not only the presence of first rank (or certain other) symptoms, but also that these "[lead to] a deterioration in life functioning," that is, functioning in employment, in relationships and so forth.

Even this approach has difficulties, however. Some of these are of the general logical kind noted above in relation to causally-defined diseases. Then there is the problem of what should count as "deterioration." We will return to this in the next section: but we can see, at least, that had Sara's voices led her into a minority sect rather than to her local

church, or perhaps into the life of an ascetic hermit, we might have been less inclined to regard them as benign. We might have had a similar reaction had Simon lost his court case. This is not to say that such value judgments would be justified, of course. It is rather to indicate that the distinction between spiritual experience and psychopathology, even in the terms of the DSM-IIIR's own criteria, turns not just on objective scientific facts (the basis of genuine "diseases" according to the medical model, Boorse 1975), but on value judgments. We return to this in the next subsection.

Leaving aside for the moment the question of evaluation, there is still a problem for this approach in defining the particular *kind* of deterioration involved. Merely that an experience leads to *deterioration* in life functioning is not sufficient for that experience to be an illness. Sloth for instance, or being disorganized, may lead to all the consequences listed in DSM III-R. Similarly, in the present series, benign spiritual experiences **[End Page 51]** led to benign consequences, but they *could* have led to any of the consequences listed in DSM III-R. Had they been malign spiritual experiences, probably they *would* have led to these consequences. But this would not, in and of itself, have required that the experiences themselves (any more than sloth) be reclassified as pathological.

The point is that the persuasiveness of the DSM III-R criterion of "deterioration in life functioning," such as it is, rests on a hidden assumption that the deterioration in question is due to a *pathological*, rather than some non-pathological, cause. This assumption is justified in DSM to the extent that the reason for introducing the criterion (of deterioration) is to distinguish significant psychotic symptoms from the more common "schizotypal" experiences found in the general population (see introduction above). But by the same token, in the case of psychotic versus *spiritual* experience, the criterion is question-begging. It begs the key question of how *pathological* causes of a deterioration in life functioning are to be distinguished from all *non*-pathological, including spiritual, causes. We are thus led back to the necessity for drawing this distinction, not in terms of the causes or consequences of an experience, but in terms of the experience itself.

3. The Concept of Mental Illness

The difficulties involved in distinguishing spiritual from pathological forms of psychotic experience by reference either to traditional psychopathology or to modern classifications of mental disorders, might be taken as support for one or other side in the polarized debate noted in the introduction. These difficulties, either side might plausibly argue, show the distinction itself to be a distinction without a difference. The authors of the GAP Report (1976) could argue that all psychotic experiences are ultimately pathological. Anti-psychiatrists, on the other hand, could argue that *all* psychotic experiences are ultimately spiritual, at least in the sense that experiences of this kind may be good or bad life experiences but are not illnesses.

It is the plausibility of collapsing this and similar distinctions either way which has generated the wider debate in the literature about the validity of the concept of mental illness (Fulford 1989, ch. 1). The present study underlines the difficulties faced by both sides in this debate. Those arguing *for* mental illness have generally adopted a strongly "medical" model of illness in which it is taken to be, at heart, a straightforwardly scientific notion, defined by objective norms of bodily and mental functioning. This model reflects a naive picture of science (Fulford 1989, ch. 12). But as we have already seen, the distinction between spiritual and pathological psychotic experiences turns, even by the

criteria adopted in supposedly scientific medical classifications of disease such as the DSM, on questions of value (i.e., because what is to count as a "deterioration" in life functioning depends on personal and social value norms, as noted a moment ago). Attempts have been made to objectify these norms by restricting them to "biological" criteria such as reduced life expectancy and reproductive capacity (e.g., Kendell 1975). But malign spiritual experiences may be as bad by these criteria as psychotic illnesses: and even benign spiritual experiences may lead, through self sacrifice (including martyrdom) for example, to reduced life and/or reproductive expectations. In the terms of the medical model, such experiences, therefore, would have to be regarded as involving impaired biological functioning and, hence, as diseases.

The "anti-psychiatry" side in the debate about mental illness represents a broader range of views. Some of these are directly contradicted by the present study: labeling theory, for instance, claims that mental illness is nothing more than an effect of stigmatization (Scheff 1963). In the cases reported here, Sara's experiences were largely endorsed. But Sean's and Simon's certainly were not. Then again, these cases hardly fit a "political control" model of mental illness (e.g., Foucault 1973). The essence of this model is that a label of mental illness is used as a means to discredit and then segregate those who are perceived as deviant in a given society. Sean kept his experiences to himself. But both Sara and Simon, far from being disenfranchised by their experiences, were empowered (Simon *vis-à-vis* his colleagues; Sara *vis-à-vis* her work and family). A satisfactory "political control" model of mental illness would thus **[End Page 52]** have to show why the psychotic phenomena occurring in these cases actually empowered the individuals concerned relative to the pressures of society. Laing's (1967) theory, broadly that psychosis represents a sane response to an insane society, might seem to be endorsed by these case reports, to the extent that the experiences were adaptive. Laing's theory, however, lacks discriminatory power. It fails to explain why in these cases the experiences were apparently adaptive in themselves, while pathological psychotic experiences, if adaptive at all, are only adaptive secondarily, in the way that, as already noted, other adverse experiences may be adaptive, good coming out of evil. Roberts (1991), for example, has shown how systematized delusions may be adaptive in the context of psychotic illness; although other authors have argued against the claim that psychotic beliefs have any potential utility (e.g., Lenz 1983). It is, then, the very *similarities* between spiritual and psychotic experiences which show the failure of Laing's theory in this respect.

Lack of discriminatory power is a weakness of many anti-psychiatry theories. In collapsing *all* mental illness to some *other* category of experience, they fail to explain just why the class of experiences concerned was separated out in the first place (Fulford, Smirnoff, and Snow 1993). Perhaps the most plausible anti-psychiatrist in this respect was Foucault (1973), who never denied the existence of madness as such, but argued that it was converted into mental illness, not by scientific progress but by the needs of the labor based institutions of the Industrial Revolution. Yet even here our cases challenge the views of anti-psychiatrists just as they do of pro-psychiatrists. The point is a general one, namely that as one of us has argued in detail elsewhere (Fulford 1989, ch. 1), the very *similarities* between spiritual and pathological psychotic experiences demand an account of the *differences* between them. This is true equally for both sides in the debate. Those who claim that the distinction between spiritual and pathological psychotic experiences is *real* must explain what it consists in without recourse, solely, either to form and content as employed in traditional psychopathology, or to the statistical and causal/consequential associations on which psychiatric disease classifications are

based. Equally, though, those who *deny* the reality of the differences between spiritual and pathological forms of psychotic experience must explain, straightforwardly, why these experiences only *appear* to be distinct.

Our cases thus challenge received views about the concept of mental illness, whether pro- or anti-psychiatric. An adequate theory, at least of psychotic mental illness (which is the most serious form of mental illness, after all), must explain the differences between psychotic and normal experiences across a range of phenomena involving perception, belief and ownership of our thoughts. But it must also explain, for the same range of phenomena, the differences between both these (i.e., both normal and psychotic experiences) and the spiritual experiences reported here.

Recognizing this, recent work in the philosophy of medicine has sought an approach to the concept of mental illness which is more balanced than that adopted in the traditional polarized debate. Instead of seeking to collapse mental illness either to physical illness (the pro-psychiatry stance) or to one or other moral category (the anti-psychiatry stance), this work has been concerned to explain the relationship between mental illness and physical illness as concepts which are similar in some respects and also different in others.

Two broad conclusions have emerged from this work, both of which are relevant to the present study. The first is that as against the objective models adopted by both sides in the debate about mental illness, the medical concepts in general, whether in physical or psychological medicine, and whether of disease, illness, sickness, trauma, disability or whatever, are essentially evaluative in nature (Sedgewick 1973; Agich 1983; Kopelman 1990; Engelhardt 1975; Fulford 1989, ch. 3; see also Endnote 3). It is no surprise, therefore, to find that in the present study our subjects' overall evaluations of their experiences were uniformly (though not always initially) positive. As has already been noted, good may come out of bad experiences, even from experiences of disease. A successful computer programmer, for example, may be thankful for a paraplegia which prevented her from vainly pursuing a career as an **[End Page 53]** athlete; for such a person, good *has* come out of evil; but the paraplegia, in and of itself, was, and remains, a bad thing. Whereas for our three cases, by contrast, their experiences, in and of themselves, were good. Similarly, the paraplegic could continue to regard her paraplegia, in and of itself, to be a disease with disabling consequences; whereas our three cases, by contrast, regarded their experiences, in and of themselves, to be spiritual (rather than pathological) in nature with enabling (rather than disabling) consequences. To this extent, therefore, their experiences are clearly differentiated from disease. (We return later to the importance for outcomes of how the subjects evaluated their experiences--see Implications for Clinical Psychiatry.)

This first conclusion has important clinical consequences to which we return in the next section. If illness and disease are evaluative concepts, however, it is clear that they are not sufficiently defined by a negative value judgment. Disease has to be differentiated from other negative evaluative concepts such as ugliness, foolishness and wickedness. This is partly a matter of the different kinds of phenomena, descriptively defined, to which these concepts are appropriately applied. That there is more to it than this, however, is not always sufficiently recognized in the literature. Philosophers of medicine, concentrating on the differences between health and ill-health, have been tempted to adopt a modified medical model in which, while it is acknowledged that the medical concepts are essentially evaluative in nature, it is nonetheless (though usually tacitly)

assumed that the relevant value judgments are sufficiently defined by a determinate set of descriptions, usually of bodily and/or mental functioning (illustrated in Fulford 1989, ch. 3).

Thus in the case of perceptual functioning, according to this (descriptivist) approach, psychotic perceptions (i.e., hallucinations, as defined descriptively by traditional psychopathology) would be bad, while normal or non-psychotic perceptions would be good. The fact that hallucinations *themselves* (traditionally defined) may be spiritual (good) or pathological (bad), however, shows that matters cannot be as simple as that. Either there must be some further descriptive (value-free) way of distinguishing spiritual from non-spiritual (but healthy) perceptual functioning, over and above those identified in traditional psychopathology; or, as one of us has argued elsewhere (Fulford 1989, chs. 6 and 7), there must be a (hidden) value element built into the definitions of the phenomena themselves.

The latter possibility leads directly to the second broad conclusion from recent work in the philosophy of medicine on the concepts of health and disease. The essence of this is that pathology has to be understood as being marked out primarily, not by reference to disturbances of *functioning*, but in terms of the patient's experience of *incapacity*, this in turn being defined in terms of failures (of one kind of another) of ordinary intentional *action*. "Action failure" models of this kind have been developed for health in general (Nordenfelt 1987) and psychiatric disorders in particular (Fulford 1989, chs. 7-10). In the case of physical disorders, and some kinds of mental disorder, "failure of function" approximates sufficiently to "failure of action" for the differences between them not to be significant. But it can be shown that for those disorders which are defined by failures of high-level capacities (such as perceiving and believing), an "action-failure," rather than "function-failure," account becomes necessary (Fulford 1989, ch. 10). But actions are in part actually *defined* by the values and beliefs of those performing them (White, 1968). Hence pathology, in so far as it involves these high-level capacities, and thus failures of action, cannot be defined separately from the values and beliefs of the subjects concerned. Far from being a purely objective notion, it turns out to be essentially *embedded* within the framework of values and beliefs of the individuals concerned, in relation to these high level capacities.

There are a number of clear, if indirect, indications from traditional psychopathology, as well as from recent work in the philosophy of medicine, that psychotic phenomena involve capacities of this higher level, embedded, kind. Shepherd (1961) for example, in a study of the Othello Syndrome (a delusional belief in the infidelity of one's sexual partner) commented that the status of a belief as a symptom of a psychotic mental **[End Page 54]** illness may be governed more by its consequences for action than by its phenomenological features as such. Even the DSM III-R reference to "deterioration in *life* functioning" implies, as we saw earlier, something of this kind. One of us (Fulford 1989, ch. 10) has taken this further, showing that the form of delusional thinking shares a number of (neglected) logical properties with the form of practical reasoning, and hence (since it is practical reasoning, rather than cognitive functioning, which is involved in action) that a failure of action (in this sense) is actually *constitutive*, and not merely a consequence, of psychotic disorder. On this account, then, the action failure involved in delusions is thus of a particularly radical kind, a conclusion which is consistent with the importance of delusions as the central symptom of the most serious kind of mental illness (i.e., psychotic illness--see generally, Fulford 1989, ch. 10).

This conclusion is directly endorsed by the cases in this study. So long as psychotic *phenomena* were thought to be associated uniquely with psychotic *disorder*, it was possible to argue (leaving aside the analytical considerations outlined above) that these phenomena were pathological in and of themselves. As we have seen, good may still come *of* them, as good may come *of* any evil, but the phenomena themselves were an evil.

The cases reported in the present study show, on the contrary, that psychotic phenomena may be, in and of themselves, good. And whether they are spiritual (good) or pathological (bad) depends ultimately not on some subtlety of their phenomenology (the focus of traditional psychopathology), nor on the patterns either of their statistical or cause-effect associations (emphasized by psychiatric nosology), but on the way in which they are embedded in the structure of values and beliefs by which the actions of the subjects concerned are defined. In the case of *pathological* psychotic phenomena, there is a radical *failure* of action (Fulford 1989, ch. 10). In the case of *spiritual* psychotic phenomena, action is radically *enhanced*. Instead of a failure of practical reasoning, instead of there being "literally no action" (Fulford 1989, ch. 10), the individual is empowered. Again, this is not a matter merely of good or bad outcomes or consequences. In the case of benign spiritual experiences, as in the subjects reported here, the consequences of empowerment were also benign. Good came of the experiences. In the case of malign spiritual experiences the consequences of such empowerment could well be evil.

Expressed in this rather broad way, even this is too simple. It tells us nothing about how "failure" and "empowerment" are to be distinguished. This will not always be easy--as we have seen, the conclusion that the distinction between health and ill-health involves value judgments, implies that it may sometimes not be finally decidable at all. Similarly, that the distinction involves the concept of "action," implies that it also turns on a range of essentially subjective notions--"intention," the "will," voluntariness, and so forth--none of which may be "decidable" in the way that, say, the presence or absence of a mitral heart sound is decidable. It may indeed be that at least some people who might now be considered to be "paranoid" (in the sense of being mentally ill) should be considered healthy--they may be bad, perhaps, or good, but they are not mentally ill. Yet this is not a weakness of the theory. On the contrary, a glance at any "scientific" classification of psychiatric disorders is enough to show the extent to which, notwithstanding the claims of "scientific" psychiatrists, such disorders are already defined in overtly or covertly value-laden terms (Fulford 1989, ch 8.; also 1994). It is therefore far from implausible that the distinction between spiritual and pathological forms of psychotic experience should turn on the way in which they are embedded in the structure of values and beliefs of the persons concerned. Once this is accepted, moreover, it has important practical implications. It is to these that we turn next.

Implications for Clinical Work and Research

That psychotic phenomena may be spiritual as well as pathological has implications both for clinical work in psychiatry and for research. We consider some of these implications briefly in this section. As will be seen, a common theme is that psychotic phenomena such as those described here can be understood adequately only as they **[End Page 55]** are embedded in the structure of values and beliefs by which the actions of each individual are defined.

1. Clinical Psychiatry

Taking clinical work first, then, the recognition that psychotic experiences are not necessarily pathological is important in relation to both diagnosis and treatment. As to diagnosis, the first point to make is that spiritual experiences, as such, are not only sometimes normal, or non-pathological, they are also commonplace. We have focused in this study on experiences which are closely similar in their phenomenological features to some of the psychotic symptoms defined by traditional psychopathology. Just how common or uncommon spiritual experiences of this *particular* kind may be remains to be seen. This is one area where new work is urgently needed. As to spiritual experiences generally, however, surveys have already shown that these occur commonly in the general (non-patient) population: for example, between 30-60% of the population reports moments of awareness of a spiritual presence or force (Greeley and McCready 1974; Hay and Morisy 1978; Hay 1987).

The commonplace nature of spiritual experiences, and their significance for the individuals concerned, reinforces the view increasingly expressed by authors from a number of disciplines, that greater attention should be paid to the spiritual aspects of the experiences and beliefs of psychiatric patients (Cox 1996). Psychiatric assessment routinely covers many highly sensitive areas, from suicidal feelings to sexual history; but the nearest approach to spiritual experience is a routine question in the mental state examination about "odd" experiences or beliefs. So clear a bias in psychiatric assessment may well reflect the concerns of psychiatry to be identified with a "down-to-earth" scientific view of their discipline, a view which, surely mistakenly (Sims 1994), often takes itself to be antithetical to the religious world view. But one important practical implication of the present study is to underline, if underlining were needed, the fact that however uncomfortably spiritual experience is felt to fit alongside the scientific self-image of psychiatry, psychiatrists can no longer afford to neglect the spiritual aspects of their patient's lives.

The present study underlines this point both in a general way and also specifically in relation to diagnosis. The importance of attending carefully to each individual patient's values and beliefs is recognized increasingly in relation to treatment. Many feel that in this, at least, the scientific status of psychiatry is not undermined. But there are clear pointers from a number of disciplines that in diagnosis, too, the supposedly scientific core of psychiatry (Boorse 1975), psychiatrists can no longer ignore their patient's values and beliefs--from philosophy (Fulford 1989 ch. 11; Sadler, Schwartz, and Wiggins 1994: see also Radden 1994, Wallace 1993, and others on the value-laden nature of criteria of rationality); but also from cross-cultural psychiatry and from social science (Cox 1996). The present study adds to these pointers by showing that the patient's values and beliefs are important, not just to diagnostic assessment in general, but to the diagnosis of particular psychiatric symptoms, including, in particular, the psychotic symptoms (delusions, hallucinations and disorders of thought) at the heart of traditional psychopathology.

We have not attempted in this paper to offer a full or final answer to how spiritual and pathological forms of psychotic experience are to be distinguished. Some of the relevant considerations are summarized above (and in Jackson, forthcoming b; though this is also an area for future research). In a sense the thrust of this paper is negative on this point: it is to the effect that this distinction cannot be made in all cases or decisively, solely on the

basis of traditional psychopathology and psychiatric diagnostic categories. The positive thesis *is* important though, namely that if the arguments presented here are correct, then *any* proposed basis for the distinction between spiritual and pathological psychotic phenomena must (*logically* must) recognize the crucial diagnostic relevance of the values and beliefs of the individual concerned. For, to repeat what was said earlier, these phenomena *cannot* be distinguished by form and content alone, at least as these have traditionally been understood. The distinction, rather, actually *turns on* the way in **[End Page 56]** which the experience in question is embedded in the individual's values and beliefs.

The importance of the patient's values and beliefs in this respect might seem to some, again, to run counter to the need for psychiatry to maintain its scientific credentials. It certainly raises what others may see as the "spectre" of value relativism. As one of us has shown in detail elsewhere, acknowledging the central and essential significance of the patient's values in psychiatric diagnosis (as well as treatment) does indeed show the diagnostic process to be less determinate than it is often assumed to be (Fulford, forthcoming). This is a good thing, though, not a bad thing. There will be cases where the value questions are literally undecidable: the facts are all laid bare, the meanings of the terms in which the relevant issues have been framed are transparent; but there remain clear differences between the values of those involved--the patient, his or her relatives, psychiatrists, the psychiatric nurse or social worker, and so on. Once the medical model of a value-free science of psychiatry is abandoned, however, there is no "spectre" here. There are a number of deep philosophical issues, certainly, about absolute versus relative values, for example, and about whether it is possible to adduce moral or philosophical grounds, independent of individual or social values norms, for endorsing this or that particular perspective. But the essential points are 1) that if, in fact, psychiatric diagnosis (or indeed medical diagnosis in general) is essentially value-laden, it may be positively dangerous to deny this; 2) that science itself is not as value-free as many doctors suppose; and 3) that to acknowledge this is not to invite chaos (law, after all, is not value-free, nor is aesthetics; but neither is thereby chaotic--see generally Fulford 1994 and 1996 for more detailed treatments of these points). There is work to be done when values conflict. There may even be *literal* conflict between different value systems. But even where such conflicts arise, a necessary step towards resolving them is to recognize the evaluative nature of the problem, rather than hiding behind a false assumption of value-neutrality.

If it is important to recognize the place of values in diagnosis, it is crucially important when it comes to treatment. In the first place, there are good grounds for believing that much abusive treatment in psychiatry has been made possible by the implicit adoption of a naive medical model, according to which values can safely be ignored in psychiatric diagnosis, as indeed they can in diagnosis in (some limited technical areas of) physical medicine (Fulford, Smirnoff, and Snow 1993).

With treatment, though, as with diagnosis, the present study also has a more specific implication, namely that the existence of *non*-pathological psychotic phenomena is directly consistent with, and indicates the possible value of, a cognitive problem-solving model of the phenomena themselves. Briefly, on this model psychotic phenomena are considered to be an intrinsic feature of an essentially adaptive problem solving process, which can be observed more generally in cases of inspirational creativity (Batson and Ventis 1982; Harding 1942; and Wallas 1926). It is suggested that this process is triggered by intense stress in the context of existential crises, and that the psychotic

content acts directly to resolve the triggering stress by producing a paradigm shift for the individual. Thus the process is self limiting, when the individual is able to utilize the "insight" contained in the psychotic content.

This model is described in more detail in Jackson, (forthcoming a and b). We can see broadly, though, that all three subjects described here were in difficulties of one kind or another when their experiences began (Simon and Sean acutely so); and that their experiences helped them to deal effectively with their difficulties. A cognitive problem-solving model, moreover, is consistent with the suggestion that the way in which people respond to psychotic phenomena depends in part, though sometimes crucially, on how the phenomena in question are embedded in the values and beliefs (and other structural features of the actions) of the individual concerned. The model, that is to say, is consistent with the idea that this "embedding" can play a central role in whether a psychotic experience turns out to be "radically enhancing" to action (like the cases reported here) or radically destructive (like most psychotic illnesses).

It is important to add that a wide variety of other factors, biological and psychological, may **[End Page 57]** also be important in determining which way things go in a particular case. Among other psychological factors, we might include the individual's ego-strength (Hood 1974) and their openness to new experiences (McCrae and Costa 1985). Thus Campbell (1972) says: "The mystic, endowed with native talents for this sort of thing and following stage by stage the instruction of the master, enters the waters and finds he can swim; whereas the schizophrenic, unprepared, unguided and ungifted has fallen or unintentionally plunged and is drowning." While the current study would suggest some caution about precisely how far the mystic and the schizophrenic are "in the same sea," there were indications, at least in Sara and Simon's cases, that "preparation" (a religious background in which the experiences made some sense), and "guidance" (Simon's seer and Sara's priest) and "giftedness"--or at least sufficient ego-strength to succeed, like Simon, in occupational competition
--may have contributed to a favorable outcome.

Cognitive models of this kind are in fact already being used successfully in the treatment of a variety of unequivocally pathological psychotic phenomena, including delusions and hallucinations (Kingdon and Turkington 1994; Chadwick and Lowe 1990; Chadwick and Birchwood 1994; Fowler, Garety, and Kuipers 1995). If such treatments prove effective, they could be an important complement to traditional drug treatments and social and psychological interventions. If they prove effective, moreover, diagnosis itself will no longer be therapeutically neutral. For a direct consequence of the model is that the way things go in a particular case will sometimes depend crucially on contextual factors, on the extent of support and validation within the socio-cultural context, a context which may include, and include crucially, the process of diagnosis itself.

This, it should be emphasized, is not to say that all psychotic experiences are (even potentially) healthy. Far from it. As we pointed out in the last section, nothing in the present study undermines the validity of the idea that psychotic phenomena may be and often are pathological. But the study shows that at least some of the psychotic phenomena recognized by traditional psychopathology are not *necessarily* pathological; and hence that other factors (including the responses of those around the subject) may be important in determining how a given phenomenon is experienced.

Returning to the subjects described here, then, they clearly believed their experiences to

be authentic (in having an external spiritual source), and they evaluated them positively (taking their experiences to be completely supportive and benign). In terms of a problem-solving model, if the experiences had been evaluated less favorably (including, for example, as symptoms of mental illness), the subjects concerned might have been left in their state of crisis, and a further cycle of (perhaps more bizarre) experiences could have ensued. For some, social feedback is probably a crucial element in the process of evaluation. Sara, for example, explicitly described her experiences as "terrifying" before they were validated by her priest. For others, such as Sean, the experiences were evaluated independently of any social feedback; indeed he retreated from such feedback (as from his wife) when he realized it was likely to be negative. At all events, it is clear that how such phenomena are experienced and dealt with by the person concerned may be critically influenced by the responses of those around them, notably, it should be added, authority figures such as priests and doctors.

We are brought back, then, to the need for a new approach to diagnosis in psychiatry, one which is more sensitive to the beliefs and values of individual patients. This is implicit in the work of the authors cited above, developing cognitive models for the treatment of a wide variety of psychiatric symptoms. What all these models have in common is a recognition of the importance of the embedded nature of these experiences, of the role of what are sometimes called meta-cognitive processes, in determining the affective and behavioral consequences of a given experience. And what a cognitive problem-solving model implies, therefore, is that the process of diagnosis--the way diagnosis is carried out, what is attended to and what neglected, and how the individual's experiences are responded to--will not be neutral with regard to outcome.

It is perhaps worth adding, finally, that work in these areas shows just how individual and **[End Page 58]** idiosyncratic (and hence non-intuitive) evaluations may be. We have written here, perhaps rather loosely, of "benign" and "malign" spiritual experiences. But as Chadwick and Birchwood (1994) have shown, the way in which an experience is evaluated by a given individual seems often to be relatively independent of its manifest content and to be determined more by the subjects' beliefs about its origin: a voice telling one subject to kill himself was believed to be "benign" in origin, for example, while voices ordering apparently trivial actions (e.g., to tie up your shoe laces) was believed to be malign. Such beliefs, in turn, were found to influence how subjects responded; they resisted those voices believed to be malign but went along with those believed to be benign. The subjects' beliefs also influenced the focus of therapy: if a voice was believed to be "omnipotent" and evil, therapy had to focus on these beliefs rather than on the voices as such, on their source and meaning and on the perceived consequences of disobedience. The importance, therefore, in diagnosis, of directly assessing not only the phenomenological features of an experience, but also the way in which it is embedded in the framework of a given person's beliefs and values, is again emphasized.

2. Research

Recognizing both the commonplace nature and value-embeddedness of psychotic phenomena is important in a number of ways for research. In the first place, there is the general point that a failure to recognize the frequency with which spiritual experiences occur has led to major biases in research. As we noted earlier, a majority of the authors given in the table below based their conclusions either on the accounts of historically acclaimed mystics or on William James's case material gathered at the turn of the

century. Not only are such cases difficult to assess because of their historical and cultural remoteness (Ward 1989) but they represent, in some respects, the "cream" of spiritual experiences rather than more everyday phenomena. Research in this area has thus been based on a restricted and possibly atypical sample.

The same may be true, at least up to a point, of medical research on psychopathology. This is because doctors have generally based their conclusions about psychopathology primarily on their experience of clinical cases rather than on well-functioning individuals. We have already noted that research on psychosis-proneness or "schizotypy" in non-clinical subjects shows that "psychotic-like" experiences, whether interpreted spiritually or in some other non-pathological way, may be relatively widespread in the general (non-patient) population (Claridge 1987; Chapman and Chapman 1987; Slade and Bentall 1988). The majority of such experiences, it is true, can be unambiguously distinguished from psychotic *symptoms* by the criteria given in the PSE and similar clinical instruments. As we have seen, though, this is not true of *all* such experiences. And among these, experiences like those of Simon, Sara and Sean are especially significant heuristically. For whereas research on schizotypy has generally been pursued in the context of pathology (schizotypy being thought of as a predisposing factor for, or even as a mild form of, psychotic illness), spiritual experiences of the kind described here have a wholly beneficial effect in the life of the person concerned. Indeed, far from representing pathology, or any other "problem of living," they may be milestones in the individual's spiritual development. This was true of Simon, Sara and Sean; and similar responses to a wide range of other spiritual experiences have been reported in the literature (Maslow 1964; Hardy 1979; Maxwell and Tschudin 1990). As already noted, though, new epidemiological research is needed to establish the prevalences of psychotic phenomena of different kinds.

Such phenomena are important, however, not just to psychopathology taken as it were in isolation, but to its links with such areas of "hard" science as dynamic brain imaging and neuropsychological research. Traditional psychopathology has recently been challenged from both these disciplines. A number of authors, for example, have noted the need for more sophisticated models of psychopathology if we are to make sense of the results of new, real time, methods for exploring brain functioning (Harrison 1991; Spence, forthcoming a and b; Spitzer 1995). And a widely based challenge to traditional "syndromal" disease **[End Page 59]** categories in psychiatry is currently underway from cognitive neuroscience (see Bentall, Jackson, and Pilgrim 1988; Charlton 1995, and responses by Bentall 1995, David 1995, and Marshall and Halligan 1995; see also Persons 1986).

Traditional psychopathological concepts, derived as they have been from the relatively restricted group of subjects who come by one means or another to the attention of doctors, are unlikely to prove adequate in respect of either of these challenges. Neuropsychology, it is true, has tended to take a wider view, encompassing, as we saw a moment ago, schizotypal subjects as well as those with psychotic disorders. But the subjects reported in the present study show that a satisfactory model must take a still broader view. Schizotypal subjects are important to neuropsychology because they experience psychotic symptoms in the absence of full-blown psychotic disorder. But their importance in this respect is usually regarded as still being in the context of pathology. The present study shows that an adequate model of psychotic phenomena must go beyond this. It must show not only how such phenomena can occur in the absence of full-blown disorder, but how they can occur in the context not of disorder at all but of

highly adaptive life experiences. To the extent, then, that this distinction--between disorder and adaptive reaction, between the pathological and the spiritual--turns on the embeddedness of psychotic phenomena in the values and beliefs of the individuals concerned, it is unlikely that a psychopathology which is capable of accommodating the distinction will be developed within the restrictions of the traditional (exclusively scientific) medical model. Just how such a psychopathology will be developed remains an open question. But as one of us has argued in detail elsewhere (Fulford 1993 and 1994), it is likely that this will require the combined resources of new empirical and mathematical techniques for investigating brain functioning together with the conceptual insights of modern philosophy of mind.

Conclusions

The three cases discussed in this paper, together with the overall results of the study reported elsewhere (Jackson, forthcoming a), show that psychotic phenomena may occur in the form of essentially benign spiritual experiences as well as in the better recognized contexts of schizotypal personality trait and of psychotic disorders such as schizophrenia. This finding suggests that psychotic phenomena themselves must be understood rather differently from the way in which they have traditionally been conceived. We have explored this conclusion here mainly at a conceptual level, showing that the frameworks, respectively, of traditional psychopathology and nosology, and of "medical" models of mental illness, all fail to account for the differences between spiritual and pathological forms of these experiences. To account for this we have had to consider them as embedded in the structure of each individual's values and beliefs, this in turn being the key to whether (as in spiritual experiences) they are action enhancing, or (as in pathological experiences) action destroying. The "embedded" nature of these phenomena has been shown to be reflected also in the kind of neurocognitive model required to explain phenomena of this kind, and in recent cognitive models for treating psychotic symptoms.

As to the distinction itself, between spiritual and pathological varieties of psychotic phenomena, the study endorses neither side in the traditional polarized debate. It is clear that if the analysis offered here is right, psychotic experiences (like non-psychotic) may sometimes figure as symptoms of illness, sometimes not. Thus those anti-psychiatrists who would collapse *all* psychotic phenomena to spiritual or other moral categories are wrong. Equally though, psychotic phenomena are not just like the symptoms of physical illness (such as pain). All diagnosis is, in the terms of the analysis outlined above, value-embedded, at least in principle (Fulford 1989, ch. 4). The difference, though, and it is a crucially important difference, is that in the case of experiences of the kind reported here, the scope for legitimate differences in the way in which we evaluate them is far wider than in (many areas of) physical medicine. Psychotic phenomena, then, are in this sense more critically "embedded" and hence cannot be considered separately from the structure of each individual's values and beliefs. **[End Page 60]**

This is a conclusion which, as we have seen, may appear to be at variance with traditional objectivist views of psychiatric diagnosis. We have argued, however, that it is fully consistent with the requirements of recent neurocognitive approaches to diagnosis, treatment and research. We would add, finally, that it is also essential to an understanding of psychiatry itself as a human science.

Mike Jackson, D. Phil., D. Clin. Psy., Department of Psychology, University College of

North Wales, Bangor, Gwynedd, LL57 2DG, United Kingdom; *K. W. M. Fulford*, D. Phil., FRC Psych., Professor of Philosophy and Mental Health, University of Warwick, Coventry, England CV4 7AL, U.K.

Acknowledgments

We are grateful to the Alister Hardy Centre, Westminster College, Oxford for the generous facilities offered to one of us (MJ) in the course of the study from which the cases described here were drawn. MJ was also in receipt of an award from the Alister Hardy Centre at the time of this study. We are also grateful to the many comments and suggestions made by the referees (including the example of paraplegia in the discussion).

Footnote

1. References to PSE symptom numbers are all as in Wing, Cooper and Sartorius, 1974.

Endnotes

1) Terminology

Calling the phenomena discussed here "psychotic" may seem to beg the question of their pathological origins. The term "psychotic" is sometimes used colloquially to mean "very mad" or "severely mental ill." In psychiatry, similarly, it is used in a more technical, though not uncontentious, sense to describe a particular class of severe mental illness characterized by the presence of specific psychotic symptoms, such as hallucinations (see, for example, Gelder, Gath, and Mayou 1983).

We opted to retain the term "psychotic" in this paper in order to emphasize that the experiences reported by our three subjects were phenomenologically identical with the psychotic *symptoms* defined in standard psychiatric texts. The argument of the paper is thus to the effect that psychotic *phenomena* (descriptively defined) may be either pathological (as in schizophrenia and other psychiatric illnesses) or non-pathological (as in the spiritual experiences reported here).

We should like to emphasis two further points. 1) Our use of the term "psychotic" is certainly not intended to imply that spiritual experiences are, somehow, signs of mental disorder. On the contrary, part of the motivation for the study was to underscore the dangers of false assimilation. 2) In this paper, we focus in particular on the basis of the distinction between *spiritual* and pathological psychotic phenomena. Spiritual experience, however, is not the only non-pathological context in which psychotic phenomena may occur. As we note in the paper, hallucinations, in particular, are widely reported in the general population; the anthropological literature, similarly, is a rich source of other kinds of non-pathological psychotic phenomena; and even in the present study, one of our subjects (Sean) placed a secular rather than a religious interpretation on his experience.

2) Some Approaches to Distinguishing between Spiritual Experience and Psychopathology

[Table 1]

Traditional approaches to this highly problematic distinction can be divided broadly into two categories: causal (including both cause and effect) theories, and phenomenological. Causal theories generally explain the similarities between spiritual experience and psychopathology by supposing that they share a common underlying generative process; the differences between them are then variously ascribed to biological, psychological or socio-cultural factors (James 1902; Underhill 1960; Campbell 1972; Buckley 1981). In the concluding section of the paper, we indicate how such factors might be integrated, using the framework of a cognitive "problem-solving" model. As a basis for the *distinction* between spiritual and pathological experience, however, causal theories, as noted in the paper, beg the question

Phenomenological theories address the question but, as illustrated in the Table, they come in a bewildering variety of forms. This partly reflects the heterogeneity of the phenomena themselves. The clinical concept of "psychosis" is notoriously broad in scope, so much so that psychiatrists have sometimes sought to abandon it altogether (e.g., Lewis 1934; American Psychiatric Association 1980). There is no agreement, either, on the criteria for the genuinely mystical. Deikman (1977), for instance, in a critical review of the GAP Report on Mysticism (1976), argued for the importance of the distinction between lower level sensory-emotional experiences and transcendent knowledge of fundamental reality. This distinction finds some support in the writings of those mystics who distinguished between "higher" intellectual and "lower" corporeal visions (St Angele de Foligno 1927, 279-293; see also Underhill 1960, 170 *seq*). However, while this successfully excludes florid psychotic phenomena, not all mystics would accept the distinction. Julian of Norwich, for instance, stressed the sensual elements of mysticism in her description of the supreme experience of God: "Him verily seeing and fully feeling, Him spiritually hearing and Him delectably smelling and sweetly swallowing" (quoted in Underhill 1960). At a more mundane level, this diversity of understanding is reflected in the wide variety of responses to charismatic phenomena across the spectrum of the contemporary Christian church.

3) Disease, Illness, and Other "Medical" Concepts

The distinction between illness and disease is, broadly, that between the patient's subjective experience and the specialist's expert knowledge (see e.g., Boorse 1975; Fulford 1989, ch. 4). We do not discuss this distinction in detail in this paper since it is the patient's experience with which we are most directly concerned. In so far as disease includes specialized knowledge of causes, some of the points made in the discussion section are relevant, in particular that knowledge of causes (and by implication of disease-process) is not sufficient to distinguish normal (including spiritual) from pathological forms of psychotic experience. We touch in the paper on various other medical and related concepts, notably from the sociology and anthropology of medicine, which are relevant in principle to our understanding of psychotic phenomena, and which certainly merit more detailed treatment. It is an open question, for example, whether more extensive use could be made of such concepts as "sickness" and "sick role."

References

Agich, G. J. 1983. Disease and value: A rejection of the value-neutrality thesis.

Theoretical Medicine 4:27-41.

American Psychiatric Association. 1980. *Diagnostic and statistical manual of mental disorders (Third edition)*. Washington: American Psychiatric Association.

------. 1987. *Diagnostic and statistical manual of mental disorders (3rd ed., rev.)*. Washington: American Psychiatric Association.

------. 1994. *Diagnostic and statistical manual of mental disorders (Fourth edition)*. Washington: American Psychiatric Association.

Arieti, S. 1976. *Creativity: The magic synthesis*. New York: Basic Books.

Batson, C. P., and L. W. Ventis. 1982. *The religious experience*. Oxford: Oxford University Press.

Bentall, R. P. 1995. Brains, biases, deficits and disorders. *British Journal of Psychiatry* 167:153-55.

Bentall, R. P., H. F. Jackson and D. Pilgrim. 1988. Abandoning the concept of schizophrenia: Some implications of validity arguments for psychological research into psychotic phenomena. *British Journal of Clinical Psychology* 27:303-24.

Bhugra, D. 1996. *Religion and psychiatry: context, consensus and controversies*. New York: Routledge.

Boorse, C. 1975. On the distinction between disease and illness. *Philosophy and Public Affairs* 5:49-68.

Buckley, P. 1981. Mystical experience and schizophrenia. *Schizophrenia Bulletin*, 7:516-521.

Butler, Rt. Hon., the Lord. 1975. *Report of the committee on mentally abnormal offenders*, Cmnd., 6244. London: HMSO.

Campbell, J. 1972. *Myths to live by*. New York: Viking.

Chadwick P., and M. Birchwood. 1994. The omnipotence of voices: A cognitive approach to auditory hallucinations. *British Journal of Psychiatry* 164: 190-201.

Chadwick P., and C. F. Lowe. 1990. Measurement and modification of delusional beliefs. *Journal of Consulting and Clinical Psychology* 58:225-32.

Chapman L. J., and J. P. Chapman. 1987. The search for symptoms predictive of schizophrenia. *Schizophrenia Bulletin* 13:497-503.

Charlton, B. G. 1995. Cognitive neuroscience and the future of diagnosis: A PC model of the mind. *British Journal of Psychiatry* 167:149-53.

Claridge, G. S. 1987. "The schizophrenias as nervous types" revisited. *British Journal of Psychiatry* 151:735-43.

Cox, J. L. 1996. Psychiatry and religion: Sociocultural aspects. In *Religion and*

psychiatry: Context, consensus and controversies, ed. D. Bhugra. New York: Routledge.

David, A. 1995. The future of diagnosis. *British Journal of Psychiatry* 167:156-57.

Deikman, A. J. 1977. Comments on the G. A. P. report on mysticism. *Journal of Nervous and Mental Disease* 165:213-17.

Engelhardt, H. T., Jr. 1975. The concepts of health and disease. In *Evaluation and explanation in the biological sciences,* eds. H. T. Engelhardt, Jr., and S. F. Spicker. Dordrecht: D. Reidel.

Foucault, M. 1973. *Madness and civilisation: A history of insanity in the age of reason*. New York: Random House.

Fowler, D., P. Garety, and L. Kuipers. 1995. *Cognitive behavior therapy for psychosis*. Chichester: John Wiley.

Fulford K. W. M. 1989. *Moral theory and medical practice*. Cambridge: Cambridge University Press.

------. 1990. Philosophy and medicine: The Oxford connection. *British Journal of Psychiatry* 157:111-15.

------. 1991. The concept of disease. In *Psychiatric Ethics (2nd ed.)*, eds. S. Bloch and P. Chodoff. Oxford: Oxford University Press.

------. 1993. Mental illness and the mind-brain problem: Delusion, belief and Searle's theory of intentionality. *Theoretical Medicine* 14:181-94.

------. 1994. Closet logics: Hidden conceptual elements in the DSM and ICD classifications of mental disorders. In *Philosophical Perspectives on Psychiatric Diagnostic Classification,* eds. J. Z. Sadler, O. P. Wiggins and M. A. Schwartz. Baltimore: Johns Hopkins University Press.

------. 1996a. Religion and psychiatry: Extending the limits of tolerance. In *Religion and psychiatry: Context, consensus and controversies*, ed. D. Bhugra. New York: Routledge.

------. 1996b. Concepts of disease and the meaning of patient-centred care. In *Essential practice in patient-centred care,* eds. K. W. M. Fulford, S. Ersser, and T. Hope. Oxford: Blackwell Science.

------. Forthcoming. Dissent and *dissensus*: The limits of consensus formation in psychiatry. In *Consensus formation in health care ethics*, eds. H. A. M. J. ten Have, and H-M. Sass. Kluwer: Philosophy and Medicine Series.

Fulford, K. W. M., A. Y. U. Smirnoff, and E. Snow. 1993. Concepts of disease and the abuse of psychiatry in the USSR. *British Journal of Psychiatry* 162:801-10.

Gelder, M. G., D. Gath, and R. Mayou. 1983. *Oxford textbook of psychiatry*. Oxford: Oxford University Press.

Greeley, A. M. 1974. *Ecstasy: A way of knowing*. Englewood Cliffs, New Jersey:

Prentice-Hall.

Greeley, A. M., and W. C. McCready. 1974. *The mystical, the twice born and the happy: An investigation of the sociology of religious experience*. Chicago: N. O. P. R.

Group for the Advancement of Psychiatry. 1976. *Mysticism: Spiritual quest or psychic disorder?* New York: G. A. P. Publications.

Harding, R. E. M. 1942. *An anatomy of inspiration*. Cambridge: W. Heffer & Sons.

Harré, R. 1993. *The laws of nature*. London: Duckworth.

Harré, R. and R. Lamb, eds. 1986. *The dictionary of physiological and clinical psychology*. Oxford: Basil Blackwell.

Harrison, P. J. 1991. Are mental states a useful concept? Neurophilosophical influences on phenomenology and psychopathology. *Journal of Nervous and Mental Diseases* 179:309-16.

Hay, D. 1987. *Exploring inner space.* 2nd edition. Harmondsworth: Penguin.

Hay, D. and A. Morisy. 1978. Reports of ecstatic, paranormal or religious experience in Great Britain and the United States: a comparison of trends. *Journal for the Scientific Study of Religion* 17:255-268.

Hood, R. W. 1974. Psychological strength and religious experience. *Journal for the Scientific Study of Religion* 13:65-71.

Jackson, M. C. 1991. "A Study of the Relationship between Psychotic and Religious Experience." Ph.D. thesis. University of Oxford.

Jackson, M. C. Forthcoming (a). Benign schizotypy? The Case of Spiritual Experience. In *Schizotypy: Relations to illness and health,* ed. G. S. Claridge. Oxford: Oxford University Press.

------. Forthcoming (b). Psychotic and spiritual experience. A case comparison study. *British Journal of Medical Psychology*.

James, W. 1902. *The varieties of religious experience*. New York: Longmans.

Jaspers, K. 1913. *General psychopathology*. Trans. J. Hoenig and M. W. Hamilton, 1963. Manchester: Manchester University Press.

Kendell, R. E. 1975. The concept of disease and its implications for psychiatry. *British Journal of Psychiatry* 127:305-15.

Kopelman, L. M. 1990. On the evaluative nature of competency and capacity judgments. *International Journal of Law and Psychiatry* 13:309-29.

Laing, R. D. 1967. *The politics of experience*. Harmondsworth: Penguin Books.

Lenz, H. 1983. Belief and delusion: Their common origin but different course of development. *Zygon* 18:117-37.

Lewis, A. J. 1934. On the psychopathology of insight. *British Journal of Medicine and Psychology* 14:332-48.

Lockyer, D. 1981. *Symptoms and illness: The cognitive organization of disorder*. London: Tavistock.

Marshall, J. C., and P. W. Halligan. 1995. Method in madness. *British Journal of Psychiatry* 167:158.

Maxwell, M., and V. Tschudin. 1990. *Seeing the invisible: Modern religious and other transcendent experiences*. London: Penguin.

McCrae, R. R., and P. T. Costa. 1985. Openness to experience. In *Perspectives in personality: Theory, measurement and interpersonal dynamics, volume 1,* eds. R. Hogan and W. H. Jones. Greenwich, Connecticut: JAI Press.

Nordenfelt, L. 1987. *On the nature of health: An action-theoretic approach*. Dordrecht: D. Reidel.

Pelosi, A. J. 1988. Mystical ecstatic and trance states. *British Journal of Psychiatry* 152:296-97.

Persons, J. B. 1986. The advantages of studying psychological phenomena rather than psychiatric diagnoses. *American Psychologist* 41:1252-60.

Proudfoot, W. 1985. *Religious experience*. Berkeley: University of California Press.

Radden, J. 1994. Recent criticisms of psychiatric nosology: A review. *Philosophy, Psychiatry & Psychology* 1:193-200.

Roberts, G. 1991. Delusional belief systems and meaning in life: A preferred reality? *British Journal of Psychiatry* 159:19-28.

Sadler, J. Z., O. P. Wiggins, and M. A. Schwartz. 1994. *Philosophical Perspectives on Psychiatric Diagnostic Classification.* Baltimore: Johns Hopkins University Press.

Scheff, T. J. 1963. The role of the mentally ill and the dynamics of mental disorder: A research framework. *Sociometry* 26:436-53.

Schneider, K. 1959. *Clinical psychopathology.* New York: Grune and Stratton.

Shepherd, M. 1961. Morbid jealousy: Some clinical and social aspects of a psychiatric syndrome. *Journal of Mental Science* 107:687-704.

Sims, A. 1988. *Symptoms in the mind: An introduction to descriptive psychopathology*. London: Baillière Tindall.

Sims, A. 1994. 'Psyche'-spirit as well as mind? *British Journal of Psychiatry* 165:441-46.

Slade, P., and R. P. Bentall. 1988. *Sensory deception: A scientific analysis of auditory hallucinations*. Chichester: John Wiley.

Spence, S. A. Forthcoming. Free will in the light of neuropsychiatry. *Philosophy, Psychiatry and Psychology.*

Spitzer, M. 1995. Conceptual developments in the neurosciences relevant to psychiatry. *Current Opinion in Psychiatry* 8:317-29.

St Angele de Foligno. 1927. *Livre de l'experience des vrais fideles*. Trans. M. J. Ferre. Paris: Edition Critique.

Underhill, E. 1960. *Mysticism. A study in the nature and development of man's spiritual consciousness.* 12th edition. London: Methuen.

Wallace, K. 1993. Reconstructing judgment: Emotion and moral judgment. *Hypatia* 8:61-83.

Wallas, G. 1926. *The art of thought*. New York: Harcourt.

Ward, C. A. 1989. The cross-cultural study of altered states of consciousness and mental health. In *Altered states of consciousness and mental health. A cross-cultural perspective*, ed. C. A. Ward. London: Sage.

Wapnick, K. 1969. Mysticism and schizophrenia. *Journal of Transpersonal Psychology* 1:49-68.

Watson, J. P. 1982. Aspects of personal meaning in schizophrenia. In *Personal Meanings,* eds. E. Sheperd and J. P. Watson. London: John Wiley.

White, A. R. 1968. Introduction. In *The philosophy of action*, ed. A. R. White. Oxford: Oxford University Press.

Wilber, K. 1980. The pre/trans fallacy. *Re-Vision* 2:51-72.

Wilkes, K. V. 1988. *Real people: Personal identity without thought experiments*. Oxford: Clarendon Press.

Wing, J. K. 1978. *Reasoning about madness*. Oxford: Oxford University Press.

Wing, J. K., J. E. Cooper, and N. Sartorius. 1974. *Measurement and classification of psychiatric symptoms*. Cambridge: Cambridge University Press.

Wootton, R. J., and D. F. Allen. 1983. Dramatic religious conversion and schizophrenic decompensation. *Journal of Religion and Health* 22:212-320.

World Health Organisation. 1992. *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva: World Health Organisation.

.