THE DIAGNOSIS OF MYSTICAL EXPERIENCES WITH PSYCHOTIC FEATURES

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Psychotic and religious experiences have been associated since the earliest recorded history, and undoubtedly before. The Old Testament uses the same term, in reference to madness sent by God as a punishment for the disobedient, and to describe the behavior of prophets (Rosen, 1968). Socrates declared, "Our greatest blessings come to us by way of madness, provided the madness is given us by divine gift" (Dodds, 1951, p. 61). Boisen (1962), who was hospitalized for a psychotic episode and then became a minister, maintained that,

> Many of the more serious psychoses are essentially problem-solving experiences which are closely related to certain types of religious experiences (cited in Bowers, 1979, p. 154).

However, not all self-reports of ecstatic divine unions indicate that the person is having a profound religious experience. In his classic study on mystical experiences, Leuba (1929) included psychiatric and epileptic patients in his sample. He noted that mystical experiences "are not characteristic of religious life alone" (cited in Perry, 1974, p. 217). Neuman (1964) observed a variety of outcomes from mystical experiences including, "catastrophe [which] can take the form of death in ecstasy, mystical death, but also of sickness, psychosis, or serious neurosis" (p. 397).

mystical experiences are not limited to religious life

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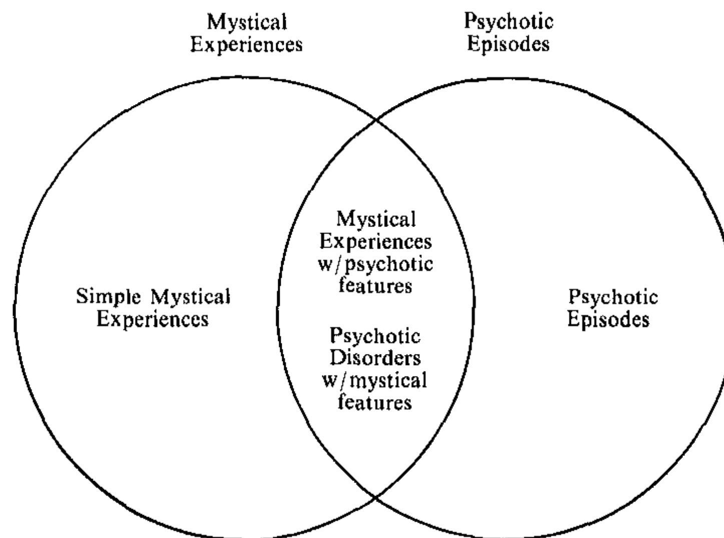
The similarity between psychotic symptoms and aspects of mystical experiences has also received acknowledgment and discussion in the psychiatric literature (Arieti, 1976; Buckley, 1981; James, 1961).

an overlap containing two diagnostic categories

This paper presents a model delineating the overlap between mystical experiences and psychotic states, and suggests guidelines for making diagnostic and treatment decisions from a psychiatric perspective which recognizes this overlap. Figure 1 illustrates that the place of overlap contains two diagnostic categories, "Mystical Experiences with Psychotic Features," and "Psychotic Disorders with Mystical Features." Before turning to the operational criteria for making a differential diagnosis, this paper will first describe the nature of psychotic states and mystical experiences.

FIGURE 1

RELATIONSHIP BETWEEN MYSTICAL EXPERIENCES AND PSYCHOTIC EPISODES



PSYCHOTIC STATES

In standard psychiatric practice, a confusion exists over the use of the term "psychotic." The *Diagnostic and Statistical Manual of Mental Disorders (Third Edition)* (DSM-III, APA, 1980) guides diagnostic practice throughout hospitals and mental health centers in the United States. Its definition of psychotic is similar to the other diagnostic systems used internationally (World Health Organization, 1977). The manual delineates two meanings for the term psychotic, one being a temporary state, and the other a mental disorder with life-long implications.

> *Psychotic.* A term indicating gross impairment in reality testing. It may be used to describe the behavior of an individual at a given time, or a mental disorder . . . (p. 367).

Individuals with severe mental disorders have been found in all civilizations and throughout recorded history (Westermeyer, 1985; Rosen, 1968). The Bible describes persons who wandered around and talked to themselves. In an ancient commentary on the Bible, the psalmist David speaks of madness,

> Master of the Universe . . . what profit is there for the world in madness? When a man goes about the marketplace and rends his garment, and children run after him and mock him, is this beautiful in Thine eyes? (Midrash on Psalm 34).

In Biblical times, such individuals were allowed to roam at large unless they were violent, in which case they were confined at home and possibly restrained as well.

Many persons with mental illnesses, especially psychotic disorders, require help from society for basic support, accommodations, companionship and a meaningful life. A large percentage of the growing population of the homeless are individuals with mental illnesses. These people are choosing to avoid society's degrading way of providing them support. Others are too overwhelmed by the complexities of the mental health bureaucracies to obtain any aid. Both the recipients and care-givers agree that the mental health system does not meet the needs of those with psychotic disorders (Estroff, 1981). (In the section on treatment, we will return to some alternative methods by which society can better provide for the needs of individuals with psychotic disorders.)

some differences in long and short-term psychotic disorders

In contrast to long-term disorders, temporary psychotic episodes have been observed to result in improvements in the individual's functioning.

> Some patients have a mental illness and then get well and then they get weller! I mean they get better than they ever were. . . . This is an extraordinary and little-realized truth (Menninger cited in Silverman, 1970, p. 63)

> It is evident that acute schizophrenic disorganization can, at times, serve a constructive purpose (Epstein, 1979, p. 319).

Many clinicians and researchers who work with psychotic individuals have developed categories for episodes with the potential for positive outcomes: problem-solving schizophrenics (Boisen, 1962); positive disintegration (Dabrowski, 1964); creative illness (Ellenberger, 1970); spiritual emergencies (Grof

& Grof, 1985); metanoiac voyages (Laing, 1972); visionary states (Perry, 1977).

Despite the consistency of these clinical observations, current psychiatric practice does not attempt to distinguish between psychotic episodes with growth potential and those which indicate a mental disorder. Not only does the DSM-III (APA, 1980) lack a specific category for them, it does not even mention the possibility of psychotic episodes with positive outcomes. If these cases could be differentiated from cases of long-term psychotic illness, the prognosis of such individuals could be improved by providing appropriate treatment consistent with their need to express and integrate the experience in a safe environment.

MYSTICAL EXPERIENCES

The *American Heritage Dictionary* notes that the word "mystical" comes from the Greek *muestes*—someone initiated into secret rites. It is derived from *muein*, meaning to close the eyes or mouth, hence to keep a secret. The Indo-European root of these Greek terms is *mu*, which is imitative of inarticulate sounds. Given this etymology, it should come as no surprise that one of the main characteristics of the mystical experience noted by many scholars is its ineffability. For example, James (1961) noted that the mystical experience "defies expression, that no adequate report of its contents can be given in words" (p. 300). Clearly there are bound to be difficulties in describing operationally an experience which defies description by words.

characteristics of mystical experiences

Another important characteristic of the mystical experience is its ability to change the individual's life. Neumann (1964) stresses the "conformity in the psychological effect of mystical experience, in the transformation it induces in the personality" (p. 387). Among some suicidal individuals, the occurrence of mystical experiences seems to lessen the risk of suicide (Horton, 1973).

Surveys have consistently found that over one-third of the people in the United States report intense religious experiences which "lifted them outside of themselves" (Hay and Morisy, 1978; also Greeley, 1974). Thomas & Cooper (1981) conducted a methodologically-sophisticated survey study in which they developed the following strict coding criteria for defining a mystical experience:

> Awesome emotions, a sense of the ineffable, feelings of oneness with God, or the Universe . . . changed perceptions of time and

surrounding and a feeling of "knowing," coupled with a reordering of life's priorities (p. 79).

In their sample of 300 cases, they found that 1% had experiences which met these criteria. Mystical experiences cannot be considered rare events and mental health professionals as well as others need to be capable of recognizing them.

Simple mystical experiences do not raise any diagnostic or treatment issues. Certain religious groups cultivate such experiences such as the followers of the Guru Maharaji.

> Mystical experiences, analagous to an acute circumscribed hallucinatory episode, were found to be a central factor in the conversion of some of the adherents to the Divine Light Mission (Buckley & Galanter, 1979, p. 281).

the significance of cultural context

These experiences typically lasted one to three hours. Behavior and states of mind which occur in the ashrams of the East and the West could also seem psychotic, but they take place in a cultural context which promotes and guides such experiences. Ram Dass (1971) describes individuals in a "god-intoxicated" state who are undergoing a training program for mystical experience under the close supervision of a master and their peers.

Many individuals spontaneously have such experiences and are able to integrate them into their lives without the intervention of either psychiatric or religious specialists. Hardy (1979) collected first-hand accounts from a sample of over 4000 individuals who responded to his newspaper articles and advertisements requesting descriptions of religious experiences. In these reports he found a wide variety of what would be described as psychopathology in psychiatric textbooks:

Visions (18%)
Voices (7%)
Telepathy (4%)
Contact with the dead (8%)
Sense of certainty, enlightenment (19%)
Exaltation, ecstasy (5%)
Sense of purpose behind events (11%)

Every culture has a framework for explaining these phenomena (Wallace, 1959). Historically in the West, such experiences were considered signs of possession by spirits who were sometimes beneficent and sometimes not (Rosen, 1968). Buddhistic medicine also considers spirit possession the cause of unusual states including both transformative experiences and mental illnesses (Epstein & Topgay, 1982).

In contemporary Western society the widely-accepted cultural model for explaining such unusual phenomena is mental illness. In the public's judgment, non-consensual experiences such as seeing visions and hearing voices are synonymous with being insane. The lack of a positive explanation for unusual subjective phenomena makes acceptance and integration of psychotic episodes difficult for individuals in Western society.

In some cases, the individual may be having genuine religious experiences concomitant with a mental disorder, as in the case of Nijinsky (1979). Treatment of psychotic disorders which have mystical features should address both dimensions of the individual's experience.

NEED FOR A NEW DIAGNOSTIC CATEGORY

Diagnosing cases as Mystical Experience With Psychotic Features (MEPF) requires the defining of a new diagnostic category. Wing (1977), a respected authority on diagnosis, noted that,

> to put forward a diagnosis is, first of all, to recognize a condition, and then to put forward a theory about it. Theories are meant to be tested. The most obvious test is whether applying the theory is helpful to the patient. Does it accurately predict a form of treatment that reduces disability without leading to harmful side-effects? (p. 87).

reducing hospitalization and use of medication

Accurate diagnosis of MEPF cases could reduce inappropriate hospitalization and use of medication for individuals who could be treated with less stigmatizing methods which have fewer side-effects. The proposed operational criteria are intended to allow cases of positively-transforming psychotic episodes to be recognized with a high degree of accuracy (referred to as "validity") and consistency across different diagnosticians (referred to as "reliability").

Wilber (1984) suggests this is a relatively easy discrimination:

> Anybody familiar with *philosophia perennis* can almost instantly spot whether any of the elements of the particular psychotic-like episode have any universal-spiritual components, and thus easily differentiate the "spiritual-channel" psychoses-neuroses from the more mundane (and often more easily treatable) pathologies that originate solely on the psychotic or borderline levels (p. 108).

While Wilber consistently calls for more careful diagnostic assessments, he has underestimated the ease of differentiating

psychotic from spiritual experiences. The task requires familiarity with the psychiatric perspective as well as the religious and philosophical contents of the perennial philosophy (Huxley 1945). Other mental health professionals working in the transpersonal field also stress the importance of careful diagnostic assessments where questions of psychosis are concerned. Hastings (1983) states that to distinguish parapsychological from psychopathological phenomena, "the parapsychological counselor should have a knowledge of clinical psychology and parapsychology" (p. 146). Discussing the non-ordinary state of the *kundalini* experience, Sannella (1978) also suggests that a "well-trained diagnostician" is needed to differentiate between *kundalini* experiences and "a number of medical disorders that may develop some of the symptoms of the [*kundalini*] complex" (p. 100).

Diagnosis is the science of classifying illnesses into valid and reliable categories; however, it is not a precise science. At the present time, there are no reliable biological markers (lab tests or x-rays) by which to confirm or rule out diagnoses of "true" mental disorders such as schizophrenia or manic-depression. Illnesses are naturally-occuring phenomena. It has long been acknowledged by medical scientists that, despite the human desire for order, nature does not usually divide diseases (or other phenomena) into neat categories (Colby & McGuire, 1981).

The DSM-III (APA, 1980) which is based on the traditions and accumulated knowledge of Western psychiatry was used as the model for the task of creating the diagnostic category of MEPF. The current diagnostic nomenclature of DSM-III takes an empirical descriptive approach: "the definitions of the disorders generally consist of descriptions of the clinical features of the disorders" (p. 7). By focusing the nomenclature on accurate description of symptoms, onset, course and outcome, the DSM-III aims to maximize agreement between clinicians on the identification of mental disorders. Studies of the reliability of the DSM-III have shown that their strategy has been very successful in achieving high reliability for most diagnostic categories (Kendell, 1982). As Wing (1977) pointed out earlier, reliable recognition of conditions is a primary objective of diagnosis.

an empirical descriptive approach

Spitzer (1976), who headed the task force which developed the DSM-III, reminds us that "classification in medicine has always been preceded by clinicians using *imperfect* systems that have been improved on the basis of clinical and research experience" (p. 469).

The specific criteria proposed below represent hypotheses. They must be subjected to reliability studies to determine whether they achieve acceptable levels of interrater agreement. Validation studies also need to be conducted to determine whether they accomplish the objective of accurately identifying individuals whose psychotic episodes represent positively-transforming mystical experiences. Ideally a trial of this operational definition would use the MEPF criteria in a screening instrument to make diagnostic decisions in situations where discriminating mystical experiences from psychotic disorders is the issue. Follow-up evaluations over several years might be required to understand the outcomes of cases handled in this manner. This type of prospective study is the most valuable for yielding information which could lead to refinements of the MEPF criteria. In addition, studies of samples of individuals who retrospectively report MEPF episodes could also yield information useful for honing the selection criteria.

DIAGNOSTIC CRITERIA FOR THE MYSTICAL EXPERIENCE WITH PSYCHOTIC FEATURES

Psychotic State Present

the first diagnostic decision

The diagnostic decision tree (Figure 2) begins with the determination of whether or not an individual is in a psychotic state as defined by the DSM-III. Many psychotic individuals are clearly suffering and welcome aid for their mental illness, although they may resent the medically-dominated manner in which our society provides such help. In cases where the individual does not experience distress and may in fact be feeling positive toward their experience, determining whether an individual is psychotic can be a painful responsibility, which may fall to family, friends or mental health professionals.

The phenomenology (imagery, cognitions) of the psychotic condition shares many characteristics with dream experiences (Hall, 1977), hallucinogenic drug trips (Kleinman et al., 1977), spiritual awakenings (Assagioli, 1981), near-death experiences (Grof & Grof, 1980) and shamanic experiences (Halifax, 1979). The fantastic or bizarre content of a reported experience is not sufficient indication that a person is psychotic. The recent profusion of "I was taken for a ride on a flying saucer" articles in magazines such as *The National Enquirer*, the success of the film, *My Dinner With Andre*, which concerns the supernatural experiences of a play director, and the popularity of Castaneda's books on his apprenticeship to Yaqui sorcerers show that many individuals are interested in and actively seeking non-rational experiences and are establishing personal non-consen-

FIGURE 2

FLOW CHART FOR GUIDING CLINICAL DECISION-MAKING REGARDING DIAGNOSES AND TREATMENT OF CASES WITH PSYCHOTIC FEATURES

Psychotic (DSM-III definition) — YES → Overlap w/Mystical Experience; NO → Other DSM-III Dx

Other DSM-III Dx — YES → Nonpsychotic DSM-III Dx; NO → None

Overlap w/Mystical Experience — YES → Positive Outcome Likely; NO → Other Transpersonal Crisis[1]

Other Transpersonal Crisis[1] — YES → Transpersonal Crisis[3]; NO → DSM-III Psychotic Dx[2]

Positive Outcome Likely — YES → Low Risk; NO → DSM-III Psychotic Dx with Mystical Features

Low Risk — YES → MEPF; NO → Defer Dx[4]

DIAGNOSIS (Dx)	None	Nonpsychotic DSM-III Dx	DSM-III Psychotic Dx[2]	Transpersonal Crisis[3]	DSM-III Psychotic Dx with Mystical Features	Defer Dx[4]	MEPF
TREATMENT -acute	as requested by client	make suggestions for further treatment	alternatives to hospitalization unless high risk (see Soreff, 1985)	alternatives to acute hospitalization (see Lamb, 1979)	alternatives to hospitalization unless high risk (see Soreff, 1985)	hospitalization or placement in a 24-hour facility until crisis resolved	alternatives to acute hospitalization (see Lamb, 1979)
-follow-up	none unless requested	as clinically indicated	rehabilitation when indicated (see Liberman & Evans, 1985)	transpersonal psychotherapy (see Scotton, 1985)	transpersonal psychotherapy	as clinically indicated	transpersonal psychotherapy

1. No criteria for Other Transpersonal Crises are currently operational.
2. DSM-III psychotic Dx's include: Pervasive Developmental Disorders, Schizophrenic and Paranoid Disorders, Some Organic Mental Disorders, some Affective Disorders, and Psychotic Disorders Not Elsewhere Classified.
3. See Grof & Grof (1985) for a discussion of other possible transpersonal crises.
4. Allow for a resolution of crisis. Then reassess risk and diagnosis.

sual realities. While such belief systems may seem bizarre on first inspection, they may in fact be adaptive within the person's chosen psycho-social network. Laing (1967) has noted the difficulty of discriminating: "Experience may be judged as invalidly mad or as validly mystical. . . . The distinction is not easy" (p. 132).

content of experience is not discriminative

The content of an experience alone usually does not determine whether an individual is psychotic. For example, sightings of flying saucers were reported by two persons; one is a continuously psychotic hospitalized patient, and the other a "normal" control in a psychiatric study.

> The only thing I can say is that the computer transfer . . . information transfer was referred to my higher mental state from the five spacecraft I saw. Whether they are still interested in this planet or not I cannot tell you, but I do have their gift of sensory or scanning the Universe with my sensibility and my telepathy. So far I am the highest of the two.

> One time when I was in junior high school, I thought I saw a UFO. I'm pretty sure I did see one. (Interviewer: How do you explain that?) Well, I would explain that by saying that at that time there was a spacecraft from another planet that was above us. I think that there are other planets with life forms. . . . I'm convinced there's been UFOs here on earth. I guess that's a matter of opinion because nobody's proved it. (Interviewer: Were you being singled out or monitored by them?) No, but I've heard of that. (Interviewer: Have you had any kind of communication from. . .) No.

Both persons had visions of flying saucers. The psychotic person seems unaware of the fantastic nature of his claims and embellishes his account with self-aggrandizing statements. He spoke in a monotoned computer voice with distinct pauses. The non-psychotic person clearly acknowledges the extraordinary and "unbelievable" nature of his experience. However, the content of the two experiences is similar. Given the large variability in personal realities, the question of "what is real" cannot be the sole criterion used to diagnose psychotic states.

More significant is the difficulty psychotic individuals have establishing a shared "intersubjective reality" with others. Berger & Luckman (1967) describe this state of reality as occurring when all parties in an interaction feel in agreement:

> My natural attitude toward this world corresponds to the natural attitude of others, that they also comprehend the objectifications by which this world is ordered, that they also organize around the here and now of their being in it. . . . I know that I live with them in a common world (p. 23).

At the turn of the century, the founders of the nomenclature, concepts, and methods used in understanding psychotic disorders, referred to this lack of "intersubjective reality" as the "abyss of difference":

> The profoundest difference in man's psychic life seems to exist between that type of psychic life which we can intuit and understand, and that type which, in its own way, is not understandable and which is truly distorted and schizophrenic. . . we cannot empathize, we cannot make them immediately understandable, although we try to grasp them somehow from the outside (Jaspers, 1963, p. 219).

Yet understandability is the result of a two-way interaction. Laing (1982) has criticized the placing of all emphasis on the presumed patients' responsibility for making their realities understandable to others. "Both what you say and how I listen contribute to how close or far apart we are" (p. 38).

Other experts on psychotic disorders also point to the need for an interviewer to actively seek out meanings and connections in the person's accounts and to work at establishing shared understandings. Referring to the criterion of non-understandability, Romano (1978) points to his clinical experience:

> I have learned that it depends in great part on how much time you spend with a patient, how informed you are of his past and present life, and on the nature of the trust established between you and the patient (p. 1).

ability to handle commonsense levels of functioning

In determining whether a psychotic state is present, it is also necessary to assess the person's ability to handle the everyday commonsense levels of functioning. If these are not severely disrupted, the individual's unusual beliefs and experiences are not of diagnostic significance. In Buddhistic medicine, the diagnosis of psychosis hinges on the functioning of consciousness. Psychosis is considered a disruption to the normal functioning of consciousness: "One becomes like a chariot without a driver and nowhere does one find any consciousness which is under one's control (Donden, cited in Epstein & Topgay, 1982, p. 77). In Western psychiatry, the diagnosis of psychotic states is based on behavioral indicators of functioning. Signs that a person's functioning is severely impaired by a psychotic disorder include loss of vocational supports, legal problems, homicidal threats and behaviors, life-threatening behaviors, self-reported problems with thinking clearly, highly unusual and disturbing perceptual experiences.

When persons show widespread deficiencies in handling the everyday commonsense tasks involved in independent living

combined with severe inability to establish "intersubjective reality" with others in their psychosocial environment, they meet the criteria for a psychotic state. Although these criteria are presented in psychiatric terminology, the same issues usually arise first in the person's social group, e.g., community or family. In difficult cases, persons in the role of making this decision should have training in the diagnosis of psychotic disorders or consult with someone who has.

In the DSM-III, the phrase, "With Psychotic Features" is appended to some diagnoses when psychotic symptoms occur within a condition which is not one of the psychotic disorders, e.g., Major Depression with Psychotic Features. Similarly it is used in the diagnostic label proposed here to indicate the presence of the psychotic state during an essentially religious experience.

Overlap with Mystical Experiences

selection of consistently present features of mystical experience

The criteria in this section were created by surveying the literature on mystical experiences to determine which features are consistently present. This follows a strategy suggested by Buckley (1982):

> The phenomenological overlap in some aspects of the acute mystical experience and acute schizophrenia . . . suggests that the presence of similar subjective phenomena in some acute schizophrenics might be a possible marker of patients who should not receive medication (p. 430).

In addition, only characteristics of the mystical experience which could be operationalized were selected. Most definitions of mysticism are couched in theological terminology and are too abstract for achieving good levels of agreement between raters; e.g., Underhill (1911) states "The aim of every mystic is union with God" (p. 96). Leuba (1929) defines mysticism more broadly as immediate contact or union of the self with the "larger-than-self" called variously God, the Cosmos, the Absolute. Because self-reported accounts of mystical experiences are more concrete and provide better operational descriptions, they were used as sources in developing the following definition for the mystical experience. Operationalizing a definition allows for the establishment of one of the prime determinants of the usefulness of a diagnostic category—high levels of interrater agreement (Wing, Cooper & Sartorious, 1974). These five criteria (A-E), all of which must be present, constitute a template for the mystical experience.

A. Ecstatic mood. The most consistent feature of the mystical experience is elevation of mood. Laski (1968) describes it as a state with "feelings of a new life, another world, joy, salvation, perfection, satisfaction, glory" (cited in Perry, 1974, p. 84). Bucke (1969) examined the experiences of well-known mystics, leaders, and artists, as well as his own mystical experience, and noted they all shared "a sense of exultation, of immense joyousness (p. 9). James (1961) also points to the "mystical feeling of enlargement, union and emancipation" (p. 334), and claims that "mystical states are more like states of feeling than like states of intellect" (p. 300).

B. Sense of newly-gained knowledge. Feelings of enhanced intellectual understanding and the belief that the mysteries of life have been revealed are commonly reported in mystical experiences (Leuba, 1929). James (1961) describes this phenomenon of newly-gained knowledge ("gnoesis"):

historically and contemporarily reported features

> They are states of insight into the depths of truth unplumbed by the discursive intellect. They are illuminations, revelations, full of significance and importance (p. 33).

Jacob Boehme, a seventeenth-century shoemaker whose mystical experience ushered in a new vocation as a nature philosopher, reported:

> In one-quarter of an hour, I saw and knew more than if I had been many years together at a university. For I saw and knew the being of all things (cited in Perry, 1974, p. 92).

C. Perceptual alterations. Mystical experiences consistently involve perceptual alterations ranging from heightened sensations to auditory and visual hallucinations. Boehme felt himself surrounded by light during his mystical experience. Visual and auditory hallucinations with religious content are also common, e.g., Saint Therese saw angels and Saint Paul heard the voice of Jesus Christ saying "Paul, Paul, why persecutest thou me?" (Acts: 3-4).

D. Delusions (if present) have themes related to mythology. James (1961) and Neuman (1964) have both commented on the diversity of content in mystical experiences across time and cultures. The mystical experience does not have "specific intellectual content whatever of its own. It is capable of forming matrimonial alliances with material furnished by the most diverse philosophies and theologies" (James, 1961, p. 333).

Electronic media have greatly increased the repertoire of cultural material available for incorporation into both mystical and psychotic experiences. Psychotic individuals who in the past might have claimed to be St. Luke, now claim to be Luke Skywalker. Carlos Castaneda's (1971) books have become a vital source for mystical as well as delusional material.

However, Perry (1974) points out that below the surface level of specific identities and beliefs are thematic similarities in the accounts of patients whose psychotic episodes have good outcomes:

> There appears to be one kind of episode which can be characterized by its content, by its imagery, enough to merit its recognition as a syndrome. In it there is a clustering of symbolic contents into a number of major themes strangely alike from one case to another (p. 9).

mythic themes in the positive experiences of patients

Based on Perry's research and other accounts of patients with positive experiences, the following eight themes were identified as occurring commonly in MEPF:

1. Death: being dead, meeting the dead or meeting Death.
2. Rebirth: new identity, new name, resurrection, apotheosis to god, king or messiah.
3. Journey: Sense of being on a journey or mission.
4. Encounters with spirits: demonic forces and/or helping spirits.
5. Cosmic conflict: good/evil, communists/Americans, light/dark, male/female.
6. Magical powers: telepathy, clairvoyance, ability to read minds, move objects.
7. New society: radical change in society, religion, New Age, utopia, world peace.
8. Divine union: God as father, mother, child; Marriage to God, Christ, Virgin Mary, Radha or Krishna.

As mentioned earlier, these same themes are found in many transpersonal experiences. When the psychotic patient projects these inner mythic themes onto outer reality, such beliefs meet the psychiatric criteria for delusions. Unfortunately, most of these experiences get squashed out in the first few days of treatment with medications. Unless the person is permitted to remain longer in an unmedicated psychotic state, the type of assessment suggested here is impossible. A structured phenomenological interview such as the Present State Examination (Wing, Cooper & Sartorious, 1974) will also help to determine the presence of mythic themes.

However, the following quotations from schizophrenic patients illustrate that not all delusions have content relatable to the eight mythic themes described above. These delusions typically occur in chronic schizophrenia (Hamilton, 1984) and would not be indicative of a MEPF:

> My brain has been removed.
> A transmitter has been implanted into my brain and broadcasts all my thoughts to others.
> My parents drain my blood every night.
> The Mafia is poisoning my food and trying to kill me.
> My thoughts are being stolen and it interferes with my ability to think clearly.
> The person claiming to be my wife is only impersonating her. She's not my wife.

examples of delusions not indicative of mythic themes

Most mystical experiences which occur in the West have Biblical content. However, some persons may meet all the above criteria for "Overlap with the Mystical Experience" without content drawn from Biblical characters and events (Perry, 1976). Familiarity with the range and variation of content in myth, religion and psychosis is essential for determining which delusions have mythic themes.

E. No conceptual disorganization. Some psychotic persons have cognitive deficits which cause them difficulty with their basic thought processes. For example, a person with a schizophrenic disorder complained, "I get lost in the spaces between words in sentences. I can't concentrate, or I get off onto thinking about something else" (in Estroff, 1981, p. 233).

Systematic comparisons of mystical experiences and schizophrenia have found that "Thought blocking and other disturbances in language and speech do not appear to accompany the mystical experience" (Buckley, 1981, p. 521). Therefore, the presence of conceptual disorganization, as evidenced by disruption in thought, incoherence and blocking, would preclude assigning a psychotic episode to the MEPF category. However, delusional metaphorical speech which may be difficult to understand, but is comprehensible, should not be considered conceptually disorganized. Andreasen (1979) has developed an interview and scale which facilitates the rating of thought, language and communication disorders.

Positive Outcome Likely

As noted earlier, the phenomenology of mysticism can be very similar or even identical to experiences which are part of

psychotic disorders. James (1961) pointed out that the textbooks on insanity contain "abundant cases in which 'mystical ideas' are cited as characteristic symptoms of enfeebled or deluded states of mind" (p. 334) Therefore additional criteria are needed to identify psychotic episodes which can be expected to have positive outcomes. The criteria suggested below are based on studies comparing patients with good outcomes to those with poor outcomes, as well as findings regarding the characteristics of patients who do not require medication during or following a psychotic episode. These studies have shown that "The sheer number of favorable prognostic symptoms . . . provides the most powerful means of predicting remission. Accurate diagnosis finishes a poor second" (Valliant, 1978, p. 638). These features are used here to predict which persons will have positive outcomes from their psychotic experiences. Conversely, the absence of these features is predictive of a poor outcome.

criteria predictive of positive outcome

At least two of the following four criteria must be present:

1. Good pre-episode functioning as evidenced by no previous history of psychotic episodes, maintenance of a social network of friends, intimate relationships with members of the opposite sex (or same sex if homosexual), some success in a vocation or school (Goldstein, 1970; Rappaport et al., 1978; Valliant, 1964).
2. Acute onset of symptoms during a period of 3 months or less. (Six months or longer onset is associated with poor outcome (Robins & Guze, 1970; Sartorious, Jablenski & Shapiro, 1978).
3. Stressful precipitants to the psychotic episode such as major life changes: a death in the family, divorce, loss of job (not related to onset of symptoms), financial problems, beginning a new academic program or job. Major life passages which result in identity crises, such as transition from adolescence to adulthood, should also be considered (Stephens, et al., 1966; Valliant, 1964).
4. Positive exploratory attitude toward the experience as meaningful, revelatory, growthful. Research has found that a positive attitude toward the psychotic process facilitates integration of the experience into the person's post-psychotic life (McGlashan & Carpenter, 1981).

Low Risk

Psychotic disorders can be the basis for homicidal and suicidal behaviors. Both John Lennon and President Reagan were shot

by persons with previously diagnosed psychotic disorders. Arieti & Schreiber (1981) have described the case of a multiple murderer whose auditory hallucinations from God and delusions of being on a religious mission fueled his bizarre and bloody killings. Some psychotic patients are obsessed with themes of sexual molestation of children.

Assessment of dangerousness and suicidality are legal responsibilities of licensed mental health professionals. However, others in the psychotic individual's network usually make the initial referrals because of verbal or behavioral threats. Strictly speaking, the level of risk to self or others is not a diagnostic question. However, it has important implications in the area of treatment.

This exclusionary criterion should be implemented only if the danger seems immediate and severe. Behavior which appears bizarre, but presents no risk to self or others, does not warrant use of this criterion. There is no information about whether dangerousness and suicidality would be different for individuals who meet the "Overlap with Mystical Experience" and "Positive Outcome Criteria."

CASE EXAMPLE

application of criteria to the case of Howard

To illustrate the use of this proposed diagnostic approach, the MEPF criteria are applied below to the experiences of a person whose psychotic episode was a positively-transforming mystical experience. The case of Howard (Lukoff & Everest, 1985) will be presented in detail to illustrate how persons in a MEPF episode appear to traditionally-trained mental health professionals as well as to transpersonally-oriented therapists.

Psychiatric perspective. It is important for the transpersonal clinician to put on "psychiatric spectacles." A high proportion of psychotic individuals encounter mental health professionals during their episodes. Professional training teaches them to diagnose and treat non-ordinary experiences as pathological. Transpersonal clinicians have taken on the responsibility for altering the current approach of traditional mental health professionals toward non-ordinary experiences so that they are not automatically seen as indications of illness (Grof & Grof, 1985). This requires the ability to dialogue with mental health professionals and understand their diagnostic approach when faced with cases of MEPF. In addition, to separate MEPF from psychotic disorders with mystical features requires the use of some mental health concepts and terms.

The preceding article "The Myths in Mental Illness," contains Howard's subjective account of his Mental Odyssey and discusses his experiences from the transpersonal perspective as a Hero's Journey. Psychiatric terminology was not used to describe his experience. How would Howard's episode be viewed by professionals in the field today? Today's mental health professional would first set out to determine if the patient were psychotic and required hospitalization. On what basis would this decision be made? According to the DSM-III, "Direct evidence of psychotic behavior is the presence of either delusions or hallucinations without insight into their pathological nature" (p. 36).

determining the presence of hallucinations and delusions

Most mental health professionals would conduct an interview to determine the presence of specific types of hallucinations and delusions as defined by the DSM-III. What types of psychotic symptoms would be considered present in Howard's Mental Odyssey? To answer this question, the author administered a one-hour retrospective mental status exam to Howard (Wing, Cooper & Sartorious, 1974). This type of interview is designed to elicit and label hallucinations and delusions. The following is a re-examination of Howard's Mental Odyssey at the symptom level.

The DSM-III defines a delusion as,

> a false personal belief based on incorrect inference about external reality and firmly sustained in spite of what everyone else believes and in spite of what constitutes incontrovertible and obvious evidence to the contrary (p. 356).

During his Mental Odyssey, Howard made incorrect inferences about external reality, e.g., he thought that death rays were being projected at him by another patient. He did not accurately discriminate between his inner subjective experiences and objective perceptions of the world. He sustained these beliefs despite the insistence of everyone else that he was wrong. From the transpersonal perspective, Howard was preoccupied with his mythic inner reality. Nevertheless, in projecting these beliefs onto outer reality, he would be considered delusional from the psychiatric perspective.

Based on the results of the mental status examination, Howard was assessed as having the following delusions: Thought Insertion, Reference, Assistance, Grandiose Abilities, Religious, Paranormal. (Table 1 gives examples from the retrospective interview and from his account which support these ratings of delusions.)

TABLE 1

SYMPTOMS FROM HOWARD'S MENTAL ODYSSEY*

PSYCHOTIC SYMPTOMS

DELUSIONS OF THOUGHT INSERTION: "It seemed as though these words were entering from an outside source . . . not forged out of my own cognitive processes."

symptoms indicated in mental status examination

DELUSIONS OF REFERENCE: "Mexican guy was there for a specific purpose—to test me, my will. Janitor knew more than he seemed to know, had another function."

DELUSIONS OF ASSISTANCE: [The events surrounding hospitalization] "were preparing me for Enlightenment and mastery over eternity, time and space."

GRANDIOSE ABILITIES: "I was the Pied Piper—calling people in to the experience to show it could be done, to open the door so others could come through." (Also, his belief in his special powers to control forces e.g., the elevator.)

RELIGIOUS DELUSIONS: "I would be one of the first of a series of people to enter the Kingdom of Heaven."

PARANORMAL DELUSIONS: (Rays from the direction of Death were projected against his will.)

VISUAL HALLUCINATIONS: "I saw the face of Death laughing. In my hospital room, saw three yellow birds. Sky was brilliant orange."

TACTILE HALLUCINATIONS: [When rays were projected at my stomach] "I felt a dull stabbing in my solar plexus . . . poked or pressed by a blunt object."

BIZARRE BEHAVIOR: Ritualized behavior including walking in figure 8's, turning in different directions and whistling and yelling incomprehensible words.

AFFECTIVE SYMPTOMS

ELEVATED/EXPANSIVE MOOD: Reported feeling "ecstatic" for 3-4 days before hospitalization and throughout the 2 months in the hospital.

OTHER MANIC SYMPTOMS: Increased activity, talkativeness, flight of ideas, inflated self-esteem, distractibility.

*The quotations are from the Present-State Examination Interview and the material in parentheses is taken from the previously published account of Howard's experience.

The DSM-III defines a hallucination as, "A sensory stimulus without external stimulation of the relevant sensory organ" (p. 359). Some of Howard's experiences fit this definition. Again, based on the mental status exam and his account, he was assessed as having visual and tactile hallucinations. Howard was also rated for bizarre behavior (Table 1).

In addition to the above psychotic symptoms, Howard also showed symptoms considered characteristic of Affective Dis-

order, e.g., Bipolar Disorder, formerly called manic-depression. He was rated for elevated mood and for five symptoms listed in DSM-III as characteristic of a manic episode.

Because of the mixture of both psychotic and affective symptoms, Howard's case presents a diagnostic dilemma. At the time of his hospitalization, Howard's psychotic symptoms led to his being assigned the DSM-I (APA, 1952) diagnosis of Acute Schizophrenic Reaction. (Actually, since the DSM-II [APA, 1968] was in effect at the time, his proper diagnosis should have been Acute Schizophrenic Episode, 295.4.) He was labelled, medicated and treated as a schizophrenic patient. How would Howard be diagnosed within the DSM-III? In the latest edition, DSM-III (APA, 1980), Howard would meet the symptom criteria for both Schizophreniform Disorder (schizophrenia of less than 6 months duration) and Bipolar Disorder, Manic Type. (Brief Reactive Psychosis would be ruled out since the symptoms persisted for over 2 weeks.) In cases where criteria for both a Schizophreniform and an Affective Disorder are met, the differential diagnosis hinges on whether there is *preoccupation with mood-incongruent hallucinations or delusions or bizarre behavior either before or after the manic symptoms* (p. 214). Persisting or pre-dating mood-incongruent features would indicate a Schizophrenic Disorder whereas their absence would result in a diagnosis of Bipolar Disorder.

Howard's case presents a diagnostic dilemma

In Howard's case, there were transient mood-incongruent features, i.e., psychotic symptoms not related to his elevated mood such as the delusion of death rays being projected at him and seeing the face of Death. However, they did not persist outside the period of his elevated mood. Thus, he more closely meets the criteria for DSM-III Bipolar Disorder, Manic with Mood-incongruent Psychotic Featurers (296.44).

Transpersonal perspective. The following is an examination of Howard's experience in terms of the MEPF diagnostic category. Results from the mental status examination along with material from the self-report of his experience (Lukoff & Everest, 1985) are utilized to determine the presence of the MEPF criteria.

I. Overlap with the mystical experience

A. Ecstatic mood. After first reporting that his experience was "beyond words," Howard later went on to describe his mood with words including "ecstasy" and "rapture." Despite finding no support or acknowledgement of his situation, this mood persisted throughout the entire two months of his hospitalization.

B. Sense of newly-gained knowledge. Howard believed that he had unlocked some elemental truths of universal importance. He felt his insights were of such importance that the scientific community should study and document what he was discovering.

C. Perceptual alterations. While in his hospital room, Howard had visual hallucinations of yellow birds against a brilliant orange sky. He also saw the face of Death in a tree stump.

D. Delusions with mythologically-related themes.

Death: Howard saw the face of Death and agreed that he would kill people if necessary to fulfill his mission.

Rebirth: Howard felt he had been reborn into a new identity as the albatross.

Journey: Howard thought he had the mission to show others the way into the Mental Odyssey experience and that he was being prepared for Enlightenment.

evaluation in terms of overlap criteria

Encounters with spirits: Howard communicated with his muse and the Devil interfered with his trip up the mountain.

Magical powers: Howard believed he had acquired special powers such as mastery over time and space and the ability to summon elevators at will.

New society: Howard thought he was the Pied Piper heralding in a new society.

E. No conceptual disorganization. Although Howard's metaphorical use of language was difficult for others to understand at times, he never showed incoherence or thought-blocking. His ideas were always expressed lucidly.

These examples show that Howard met all five (A-E) of the criteria which indicate overlap with the mystical experience.

II. Positive outcome likely

Good pre-episode functioning was evidenced by Howard's lack of any previous psychotic episodes, his completion of high school and his network of male friends. Acute onset of symptoms occurring during a span of a few days meets this criterion. A positive attitude toward the experience was maintained by Howard throughout his hospitalization.

While there was no obvious external stressor, he was at an age (19) when many persons experience an adolescent identity crisis (Erikson, 1980). If preoccupation with themes of identity prior to the episode could be confirmed, then he would have

met all four criteria. The three he clearly did meet would satisfy the threshold for expected good outcome.

III. Low risk

When challenged by his brother, Howard declared that he would kill people if he thought it would be necessary to achieve his mission. This type of threatening statement needs to be checked out by a clinician who is familiar both with signs of homicidal dangerousness in psychiatric patients and also with death/rebirth themes characteristic of psychosis. In Howard's case, further probing revealed the metaphorical basis of his preoccupation with death themes rather than the danger of actual homicide. He was clearly not a suicide risk, so the Low Risk criterion would also have been met.

another comparison case

Interested readers who wish additional exposure to MEPF cases can read the account of Allen Ginsberg's psychotic episode and 8-month hospitalization which led to heightened artistic creativity (Portuges, 1978). This paper deliberately focuses on the psychotic episode of someone who has not become a religious leader or famous artist. While the MEPF has cultural importance in renewing areas of religion, art and society, in most cases the value of the experience is primarily for an individual's personal renewal.

TREATMENT

Through the use of medication and the lack of opportunity for worthwhile communication, Howard's experience was stamped-out and invalidated. What kind of treatment would permit individuals in the midst of psychotic episodes to emerge feeling good about their experiences and with their transformative truths intact? The pioneer (but now defunct) programs at Diabysis (Perry, 1974) and Soteria (Mosher & Menn, 1979) residential treatment homes developed techniques which allowed psychotic individuals a wide latitude of freedom for expressing their beliefs, affects, and symbolic imagery. Unfortunately treatment methods utilizing expression and exploration of psychotic episodes have not been widely incorporated by mental health professionals in private practice or at treatment sites. Part of their reluctance to apply such methods is the lack of data demonstrating that these techniques can lead to as good or better outcomes than traditional medication-based hospital programs (Lukoff et al., in press). The ability to accurately identify individuals in the midst of a MEPF could lead to wider utilization of growth-oriented transpersonal techniques with persons who could benefit from them.

Many persons in the midst of a MEPF could be treated by friends and relatives who would be willing to provide 24-hour care in a sanctuary-type environment. A variety of alternatives to acute hospitalization are being explored including treating acutely psychotic persons within their homes, in family sponsored private homes, in non-hospital "inpatient units," in religious communities (Lamb, 1979).

various approaches to treatment

Most persons in a prolonged psychotic episode as part of a psychotic disorder with mystical features can also be treated outside hospitals in residential settings with medical supervision (Soreff, 1985). Medication and structured behavioral therapies may be helpful in returning severely psychotic persons to the routines and realities of the everyday world. These individuals may also benefit from the use of expressive therapy techniques to help them integrate the powerful religious dimensions of their experience (Lukoff et al., in press). Most persons with psychotic disorders are severely deficient in basic independent living and social skills and may require rehabilitation to help them successfully integrate into society (Liberman & Evans, 1985).

CONCLUSION

Throughout her hospitalization, another person in the midst of a similar episode told the staff, "Listen . . . I've had this incredible mystical experience." Today she writes,

> Now, more than eight years later, I can look back and say, "Listen . . . I had this incredible mystical experience." It integrated and made sense of everything that had ever happened to me or that I had ever done. It showed me the meaning and purpose of life. It was a birth into a state of consciousness I did not even know existed, but which is now a permanent part of my life (Brown, personal communication).

The incidence of MEPF cases treated in hospital environments designed to suppress mystical experiences is not known. The adoption of operational criteria for identifying these individuals will lead to more accurate identification of these cases. In turn, this would promote the development of more effective treatments which allow them to continue on and return from inner journeys with their lives and psyches intact or improved.

In summary, the point made by Bowers (1979) addresses this issue:

> To evaluate psychotic experiences with regard to evidence of growth potential is not necessarily to be over-optimistic about the

> phenomenon of psychosis. It may allow us to be more precisely optimistic when the clinical data warrant, however, and urge us to re-examine our therapeutic strategies so that we foster growth whenever possible (p. 162).

a group likely to have positive outcomes

To traditionally-trained mental health professionals, the proposition that some psychotic episodes are growthful may seem to be wishful or even magical thinking. Yet, the diagnostic approach suggested in this paper adheres to the existing diagnostic practices within the mental health field. It utilizes operational criteria based on empirical studies to identify a group of persons likely to have positive outcomes following psychotic episodes.

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