

Visionary Spiritual Experiences

David Lukoff, PhD

Even though psychotic disorders can have debilitating effects, many clinicians and researchers have observed that some psychotic episodes result in improvements in an individual's functioning. Karl Menninger, often recognized as a founder of American psychiatry, noted: "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."¹ Boisen,² who was hospitalized for a psychotic episode and then became a minister who founded the field of pastoral counseling, maintained: "Many of the more serious psychoses are essentially problem solving experiences which are closely related to certain types of religious experiences."³ Perry⁴ pointed 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."

Several diagnostic categories have been proposed for such psychotic-like episodes which have potential for positive outcomes: problem-solving schizophrenia²; positive disintegration⁵; creative illness⁶; spiritual emergencies⁷; mystical experience with psychotic features⁸; metanoiac voyages⁹; and visionary states.¹⁰ In this article, the term visionary spiritual experience (VSE) will be used to encompass such experiences. The term visionary is used in the anthropological and religious literature to refer to a mental condition that leads an individual to propose changes for the entire culture. Such visionary experiences are more likely to occur in societies undergoing rapid and devastating social change, such as with the Iroquois Indian leader Handsome Lake. In the late 1700s, he spent 6 months in a state of catatonia accompanied by visions. Following these experiences, he underwent a personal transformation, communicated his visions and new insights to others, and synthesized old and new beliefs into a new religion and way of living that revitalized the culture.¹¹

However, in most cases, a VSE does not transform the culture, but adds a new dimension to the individual's spiritual life. Spirituality is used to refer to an inner experience of connection to something greater than oneself, a personal sense of the sacred and meaningful. People in the midst of a VSE often traverse the range of the world's religions and cultural



David Lukoff, PhD

history in the form of religious content and experiences that are similar to hallucinations and delusions (explored in more depth below). When they return, they often view the episode as a part of their spiritual awakening and an initiation for their spiritual journey. Jungian analyst John Perry noted that, after a VSE, "What remains . . . is an ideal model and a sense of direction which one can use to complete the transformation through his own purposeful methods."¹²

To differentiate such episodes from psychotic disorders Stanislav Grof and Christina Grof⁷ coined the term spiritual emergency:

"Critical and experientially difficult stages of a profound psychological transformation that involves one's entire being. They take the form of nonordinary states of consciousness and involve intense emotions, visions and other sensory changes, and unusual thoughts, as well as various physical manifestations. These episodes often revolve around spiritual themes; they include sequences of psychological death and rebirth, experiences that seem to be memories from previous life times, feelings of oneness with the universe, encounters with various mythological beings, and other similar motifs."

But the symptoms will resolve spontaneously with appropriate support, and can lead to improvements in wellbeing, psychological health, and awareness of the spiritual dimension in life. There are scores of self-reports and case studies documenting such outcomes.¹³⁻¹⁵

Cross-cultural and Historical Perspectives on VSE

Based on a cross-cultural survey, the anthropologist Prince concluded that "highly similar mental and behavioral states may be designated psychiatric disorders in some cultural settings and religious experiences in others" and that a certain proportion of these states "may be contained and channeled into socially valuable roles" in societies that "invest these unusual states with meaning and provide the individual experiencing them with institutional support."¹⁶ For example,

From the Spiritual Competency Resource Center, Peta Luma, CA.
Reprint requests to David Lukoff, PhD, Spiritual Competency Resource Center,
1035 B Street, Peta Luma, CA. Email: dlukoff@comcast.net

Copyright © 2007 by The Southern Medical Association
0038-4348/0-2000/10000-0635

anthropological accounts show that babbling confused words, displaying curious eating habits, singing continuously, dancing wildly, and being “tormented by spirits” are common elements in shamanic initiatory crises. In shamanic cultures, such crises are interpreted as an indication of an individual’s destiny to become a shaman, rather than a sign of mental illness.¹⁷

In Asian cultures, problems associated with spiritual practices are recognized and are distinguished from psychopathology. For example, a well-known pitfall of meditation practice is “false enlightenment,” associated with delightful or terrifying visions, especially of light.¹⁸ Beginning in the 1960s, interest in Asian spiritual practices such as meditation, yoga, and tai chi, as well as experimentation with psychedelic drugs, triggered many VSEs, some of which were problematic for their practitioners:

“The contemporary spiritual scene is like a candy store where any casual spiritual ‘tourist’ can sample the ‘goodies’ that promise a variety of mystical highs. When novices who don’t have the proper education or guidance begin to naively and carelessly engage mystical experiences, they are playing with fire.”¹⁹

The similarity between psychotic symptoms and mystical experiences has received acknowledgment and discussion in the mental health field.^{2,20–22} Both involve escaping the limiting boundaries of the self, which leads to an immense elation and freedom as the outlines of the confining selfhood melt down. The need to transcend the limiting boundaries of the self has been postulated to be a basic neurobiological need of all living things.²³ However, during psychotic episodes, if “the sense of embodied self is transcended before it has been firmly established disintegration and further fragmentation are the likely results.”²⁴

The great prophets and saints reported visions, which later were passed on to the rest of humanity as symbols of faith. People who have undergone VSEs have been esteemed and enjoyed privileged status as shamans, prophets, or saints. Socrates declared, “Our greatest blessings come to us by way of madness, provided the madness is given us by divine gift.”²⁵ In contemporary Western society, experiences such as seeing visions and hearing voices, experiencing oneself communicating with or being a religious figure are viewed as delusions and hallucinations, symptoms of a psychotic disorder. People in the midst of VSEs have difficulty obtaining support from either the healthcare system or religious institutions.

If cases of VSE could be differentiated from cases of serious psychotic disorders, the prognosis for such individuals could be improved by providing appropriate treatment consistent with their need to express and integrate the experience in a safe environment. This paper presents a model delineating the overlap between VSEs and psychotic disorders,

and suggests guidelines for making diagnostic and treatment decisions from a psychiatric perspective which recognizes this overlap.

Differences Between VSEs and Psychotic Symptoms

Hallucinations

Auditory and visual hallucinations have played an essential role in religion for thousands of years. Accounts range from Biblical prophets and saints to shamans, as well as Socrates’ famous Daemon voice. Psychiatrists have retroactively diagnosed all of them to have had mental disorders.²⁶ However, the DSM-IV specifically notes that clinicians assessing for schizophrenia in socioeconomic or cultural situations different from their own must take cultural differences into account: “In some cultures, visual or auditory hallucinations with a religious content may be a normal part of religious experience (eg, seeing the Virgin Mary or hearing God’s voice.”²⁷ In a study of visual hallucinations among Hispanic clinic patients, Lata found that “psychotic phenomena could occur in connection with spiritual experiences. Visions of loved ones who have died occur constantly, as well as visions of saints, angels, Jesus, and Mary.”²⁸

Several survey studies have shown that more than half of the normal population has some experience with voice hallucinations,²⁹ and approximately 10% of the general population have the experience of hearing a comforting or advising voice that is not perceived as being one’s own thoughts.³⁰ Hallucinations frequently occur in people during bereavement, life-threatening situations, and stressful traumatic situations such as sensory deprivation, sleep deprivation, illness, and solitary confinement.³¹ Inner voices have played a significant role in the lives of many noted individuals including Carl Jung, Elisabeth Kubler-Ross, Martin Luther King, Jr., and Winston Churchill.³² Hearing inner voices is often perceived as helpful by people who are experiencing a spiritual awakening.³³

Delusions

The DSM-IV notes that “Ideas that may appear to be delusional in one culture (eg, sorcery and witchcraft) may be commonly held in another.”²⁷ Research has confirmed the overlap between psychotic and spiritual experiences. Peters, Joseph, & Garety³⁴ assessed the incidence of delusions using a standard interview and rating criteria among members of New Religious Movements (NRMs, such as Moonies), non-religious people, Christians, and patients hospitalized for psychotic disorders. They found that those in the NRM group could not be distinguished from the inpatients by their beliefs, but could by their mood and adjustment. Detailed cases show that psychotic symptoms can occur in the context of spiritual experiences.^{13,35–37} Greenberg et al³⁸ described four young

men who explored Jewish mysticism and became psychotic. Their hallucinations, grandiose and paranoid delusions, and social withdrawal were indistinguishable from those of many mystics.

Empirical studies comparing individuals who are both religious and deluded call into question diagnostic criteria for delusions that emphasize the content (ie, bizarreness or falsity) of beliefs to classify them as pathologic.³⁹ Holding a delusion with absolute conviction is not a sign of pathology in itself because all beliefs that are personally significant tend to be held with absolute conviction.⁴⁰ A feature of normal cognition is a confirmation bias that allows us to be impervious to contradictory evidence and only notice information that confirms our preexisting beliefs.⁴¹

Altered Structure of Experience

Delusions can be differentiated from religious beliefs not by content, but by factors such as how much they interfere with one's life, and their emotional impact.³⁵ Greenberg and associates³⁸ conclude that a diagnosis of psychotic disorder rests on factors such as duration of the state, ability to control entry into the state, and deterioration of habits, rather than the phenomenology of the state itself. VSEs are usually transient and resolve completely, without leaving residual social difficulties or isolation; in contrast, psychotic disorders generally persist for a long period and involve ongoing impairment and social withdrawal.^{35,42,43}

Similarly, Tibetan and Zen Buddhism, and Tantric Hinduism provide conceptualizations of mystical states of mind that could permit psychotic experiences to be distinguished not only by emotional and behavioral consequences, but by real differences in the states themselves, such as: loss of subject/object boundaries; less ability to control attention; less ability to maintain equanimity; an inability to return to the ontological framework of consensus reality; psychological isolation; preoccupation with the mental realm; and neglect of self-care.³⁹

Differential Diagnosis Between Psychotic Disorders and VSEs

Over the past 30 years, there has developed a body of literature on approaches to distinguishing VSEs, particularly mystical experiences and spiritual emergencies, from psychotic disorders. Iatrogenic problems may occur if VSEs are misdiagnosed and mistreated, possibly contributing to poorer outcomes in industrial societies where the rate of full recovery is lower and level of impairment of persons with psychotic disorders is considerably higher than in nonindustrial societies.⁴⁴ In an interview study, "the most subjectively frightening aspect of their experience was psychiatric hospitalization itself."⁴⁵ The diagnosis of a mental disorder is still stigmatizing in contemporary American culture. The clinician's initial assessment can significantly influence whether

the experience is integrated and used as a stimulus for personal growth, or repressed as a sign of mental disorder, thereby intensifying an individual's sense of isolation and blocking his or her efforts to understand and assimilate the experience.

The DSM-IV category Religious or Spiritual Problem (V62.89) is not a mental disorder, but is listed in the section for "Other Conditions That May Be the Focus of Clinical Attention." The proposal for this diagnostic category had its roots in concerns about the misdiagnosis and treatment of spiritual emergencies.^{46,47} The inclusion of this new diagnostic category in 1994 marked the acknowledgment that distressing religious and spiritual experiences occur as nonpathological problems.

"Religious or Spiritual Problem (V62.89). This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values which may not necessarily be related to an organized church or religious institution."²⁷

VSEs warrant the DSM-IV diagnosis of Religious or Spiritual Problem even when there may be symptoms present that are usually considered psychotic, including hallucinations and delusions. In this regard, the category Religious or Spiritual Problem is comparable to the V-Code category Bereavement. The DSM-IV notes that even when a person's reaction to a death meets the diagnostic criteria for Major Depressive Episode, the diagnosis of a mental disorder is not given because the symptoms result from a normal reaction to the death of a loved one. Similarly, in VSEs, transient hallucinations, delusions, bizarre behavior, and interpersonal difficulties occur so frequently that they should be considered normal and expectable features.⁸

Greenberg and Witzum⁴⁸ have proposed the following criteria to distinguish between normative, strictly religious beliefs and experiences from psychotic symptoms based on their decades of work with ultra-orthodox Jews in Israel. These criteria would seem to have wider applicability. Psychotic episodes: 1) are more intense than normative religious experiences in their religious community; 2) are often terrifying; 3) are often preoccupying; 4) are associated with deterioration of social skills and personal hygiene; and 5) often involve special messages from religious figures.

Criteria for making the differential diagnosis between VSEs and mental disorders have also been proposed by Agosin,⁴⁹ Grof and Grof,⁷ and Lukoff.⁸ There is considerable overlap among all the proposed criteria. The following four criteria are based on published research on prognostic factors that predict positive outcomes from psychosis as well as the extensive case study literature on VSEs:

- 1) *Absence of medical illness.* Dehydration, drug intoxication, brain tumors, sleep paralysis, and medication

side effects are associated with hallucinations and delusions.⁵⁰ A medical examination should be conducted to rule out these causes of the symptoms.

- 2) *Phenomenological overlap with one type of VSE.* Many VSEs are anomalous experiences, which are defined as unusual experiences that appear to challenge our understanding of the world, such as mystical experiences, near death experiences, alien abduction encounters, psychic experiences, lucid dreaming, and psychedelic drug experiences. These extraordinary phenomena have often been ignored or ridiculed by mainstream psychology, even though interest in exceptional mental states dates back to William James. Turner et al⁵² examined ten varieties of anomalous experiences and found little relationship between anomalous experiences and psychopathology. Indeed, many of these experiences have been associated with claims of positive life changes following the experience. Yet they can be distressing and lead to contact with mental health professionals.

The following typology of VSEs reflects research on anomalous experiences reported in the PubMed and PsycInfo databases of healthcare and scientific literature: mystical experiences; near-death experiences; spiritual practice-related experiences; psychic experiences; alien abduction experiences; and possession experiences. The clinician needs to be able to recognize when delusions and hallucinations have themes from a VSE. More detailed descriptions of the above VSEs are available in Lukoff.^{47,53} In contrast, the following delusions and hallucinations from schizophrenics with whom I have worked do not exhibit content found in VSEs: “My brain has been removed”; “a transmitter has been implanted into my brain and broadcasts all my thoughts to others”; “the Mafia is poisoning my food and trying to kill me.”

- 3) *Prognostic signs indicative of a positive outcome.* Good prognostic indicators, validated by outcome studies from psychotic disorders,⁸ can be expected to be useful guides in predicting positive long-term outcome. They include: a) good pre-episode functioning; b) acute onset of symptoms during a period of 3 months or less; c) a stressful precipitant; d) a positive exploratory attitude toward the experience^{54,55}; e) absence of conceptual disorganization and confusion.

Systematic comparisons of first person accounts 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.”²⁰ Conceptual disorganization, as evidenced by disruption in thought, incoherence and blocking are not characteristic of VSEs. Schizophrenia is associated with cognitive deficits which cause difficulty with basic thought processes. For ex-

ample, a person with schizophrenia complained, “I get lost in the spaces between words in sentences. I can’t concentrate, or I get off onto thinking about something else.”⁵⁶ Similarly, Jung acknowledges that fragments of archetypal spiritual themes and symbols occur frequently in the experiences of psychotic persons, but points out that “the associations are unsystematic, abrupt, grotesque, absurd and correspondingly difficult if not impossible to understand.”⁵⁷ Therefore, the presence of conceptual disorganization, as evidenced by disruption in thought, incoherence and blocking, would indicate the person is experiencing something other than a VSE. Confusion has also been found to be an indicator for a poor prognosis for psychotic disorders in several studies.⁵⁸

- 4) *No significant risk for homicidal or suicidal behavior.* Hallucinations and delusions can be the basis for homicidal and suicidal behaviors. Arieti & Schreiber⁵⁹ 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.

Treatment of VSEs

Interventions range widely: residential treatment, support for a time-limited crisis with involvement of relatives, friends, support groups, and healthcare professionals, and intensive long-term psychotherapy. Choice of specific interventions depends on the intensity, duration, and type of VSE, and also on the individual and on their support network. Psychotherapy can help patients shape their VSE into a coherent narrative—to see the “message” contained in their experiences—and to create a life-affirming personal belief system that integrates their experience. Depth psychotherapy can help some individuals probe the personal meaning of their symptoms, and also see the universal dimensions of their experiences.¹⁵

Some residential approaches have also developed. Kingsley Hall, founded in England in the late 1960s by R.D. Laing and others who identified themselves as part of an “anti-psychiatry” movement, was the first attempt to provide alternative nonmedical model residential treatment. Diabysis, a Jungian-based treatment center for first-episode psychotic patients, was started by John Perry, MD and operated in San Francisco during the 1970s. Medications were rarely used. Instead, Perry encouraged clients to express and explore the symbolic aspects of their psychotic experiences. Perry reported⁶⁰ that, when clients were treated with this model, most came through their psychotic episodes within 6 to 10 weeks. Soteria⁶¹ was another residential treatment program that existed in the 1970s and provided a milieu that promoted expression rather than suppression of the contents of the patients’ psychotic experiences. It does not seem that any residential programs using this approach exist in the USA, but there are several Soteria homes in Europe.

The following 8 interventions are based on case reports of people who have recovered from a VSE,³⁶ some personal communications with others who have worked with patients in a VSE (Robert Turner, MD,⁶² a psychiatrist and homeopath, on dietary recommendations), and the literature published on programs such as Diabysis and Soteria. However, few systematic studies comparing treatments for VSEs have been conducted.

Normalize

People in the midst of VSEs need a framework of understanding that makes sense to them. "The most important task is to give people in crisis a positive context for their experiences and sufficient information about the process that they are going through. It is essential that they move away from the concept of disease and recognize the leading nature of their crisis."⁷

Lack of understanding, guidance and support can allow such experiences to become more distressful and psychopathological. Brant Cortright, PhD writes that educating the patient "gives the person a cognitive grasp of the situation, a map of the territory he or she is traversing. Having a sense of the terrain and knowing others have traveled these regions provides considerable relief in itself."⁶³

Create a Therapeutic Container

Perry,⁴ the founder of Diabysis, emphasizes that when a person's psyche is energized and activated, she needs contact with a person who empathizes, who actively encourages the process, who provides a loving appreciation of the qualities emerging through the process, and who facilitates the process rather than attempting to halt or interfere with it. Thus Perry encouraged expression of the VSE since "therapy should follow the psyche's own spontaneous movements . . . you work with what the psyche presents." Depth psychotherapists, particularly those with Jungian and transpersonal training, are uniquely prepared to provide psychotherapy for patients in VSEs because of their training in unconscious dynamics.

Help the Patient to Reduce Environmental and Interpersonal Stimulation

The person undergoing a VSE needs to be shielded as much as possible from the stimulation of the everyday world, if it is experienced as painful and interfering with the inner process.

Have the Patient Temporarily Discontinue Spiritual Practices

Meditation has triggered many reported spiritual emergencies. Meditation teachers who hold intensive retreats are familiar with this type of occurrence, and many, such as those at Spirit Rock Meditation Center, have developed strategies for managing such occurrences (R. Turner, Dietary recom-

mendations for a spiritual emergency, personal communication, 2005). Yoga, Qigong, and other spiritual practices can also be triggers. DSM-IV includes Qigong Psychotic Reaction as a culture-bound syndrome. Usually teachers advise temporarily ceasing the practice. It can be reintroduced as the person becomes more stable.

Suggest that the Patient Eat a Diet of "Heavy" Foods and Avoid Fasting

Grains (especially whole grains), beans, dairy products, and meat are considered grounding ("heavy") foods as opposed to fruit, fruit juices, and salads. Sugar and stimulants like caffeine are also not advised. (R. Turner, Dietary recommendations for a spiritual emergency, personal communication, 2005).

Encourage the Patient to Become Involved in Calming Activities

Gardening or any simple tasks, such as knitting, housecleaning, shoveling, or sorting, can be calming. Encourage the patient to participate in regular exercises. Walks are an excellent way to help a person bring their focus of attention back into their body. Walks in nature have the added benefit of enhancing tranquility and calming the mind. If the patient is a regular participant in other activities, such as swimming or biking, they could engage in that. However, competitive sports would be too stimulating.

Encourage the Patient to Use Expressive Arts, Both in Psychotherapy Sessions and at Home

Drawing, painting, making music, journaling, dancing, and other creative arts can help a person express and work through her inner experience. The language of symbol and metaphor can help integrate what can never be fully verbalized. A successful case utilizing this method was reported by Lindner⁶⁴ who treated a research physicist by encouraging him to fully explore and express his delusional beliefs that he lived on another planet and traveled into other universes. At the end of the therapy, the scientist had achieved a state of objectivity and distance from these experiences which allowed him to return from these adventures.

Evaluate for Medication

Some practitioners, such as Perry, have argued that medications inhibit a person's ability to concentrate on the inner work and impede the individual's capacity to move the process forward. However, sometimes the process is so intense that the person is overwhelmed and becomes very anxious. That person could benefit from slowing down the process. Bruce Victor, a psychiatrist and psychopharmacologist, recommends using low doses of tranquilizing or antipsychotic medication to alleviate some of the most distressing feelings and allow the person to better assimilate the experience.

It becomes a challenge to determine whether the person can actively work with the pain therapeutically toward further psychological growth. One important role of pharmacotherapy is to titrate the level of symptoms, whether they be pain, depression, anxiety, or psychotic states, so that they can be integrated by the person in the service of growth.⁶⁵

Conclusion

Polls conducted over the past 35 years have shown a dramatic increase in the percentages of people who report VSEs such as mystical, near-death, psychic, and alien abduction experiences.⁶⁶ During the last 25 years, there also has been a significant increase in participation in spiritual practices, such as meditation, yoga, Qigong sweat lodges, drumming circles, and other practices which can induce intense spiritual experiences. The majority of these experiences are not problematic, do not disrupt psychological/social/occupational functioning, and do not necessitate mental health treatment. However, with increased utilization of spiritual practices and participation in groups that induce spiritual experiences, it can be expected that the incidence of VSEs seen in treatment seems likely to increase.

James Hillman pointed out that "Recovery means recovering the divine from within the disorder, seeing that its contents are authentically religious."⁶⁶ Rarely after a VSE does an individual actually lead a transformative movement for the entire culture. However, through psychotherapy, such individuals may be able to salvage personally valid spiritual dimensions of their experience. By eliciting the patient's perspective and offering an individualized treatment strategy, clinicians are more likely to help patients having a VSE control the distressing aspects of the voices and delusions, minimize stigma and discrimination, make meaning of the experience, and achieve a full recovery.

References

1. Silverman J. Shamans and acute schizophrenia. *Am Anthropol* 1967;69: 21-31.
2. Boisen AT. *The Exploration of the Inner World*. New York, Harper and Row, 1962.
3. Bowers M. Psychosis and human growth. In: Fadiman J, Kewman D (eds). *Exploring Madness*. Monterey, Brooks/Cole, 1979.
4. Perry JW. *The Far Side of Madness*. Englewood Cliffs, Prentice Hall, 1974, p 136.
5. Dabrowski K. *Positive Disintegration*. Boston, Little Brown, 1964.
6. Ellenberger HF. *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*. New York, Basic Books, 1970.
7. Grof S, Grof C (eds). *Spiritual Emergency: When Personal Transformation Becomes a Crisis*. Los Angeles, Tarcher, 1989, p 195.
8. Lukoff D. The diagnosis of mystical experiences with psychotic features. *Journal of Transpersonal Psychology* 1985;17:155-181.
9. Laing RD. Metanoia: Some experiences at Kingsley Hall. In: Ruitenbeck HM (ed). *Going Crazy*. New York, Bantam Books, 1972.
10. Perry J. Psychosis and the visionary mind. *Journal of Altered States of Consciousness* 1977-1978;3:5-13.
11. Wallace A. Stress and rapid personality changes. *Int Rec Med Gen Pract Clin* 1956;169:761-774.
12. Perry JW. *Trials of the Visionary Mind: Spiritual Emergency and the Renewal Process*. Albany, State University of New York Press, 1998.
13. Lukoff D, Everest HC. The myths in mental illness. *Journal of Transpersonal Psychology* 1985;17:123-153.
14. Chapman J, Lukoff D. The social safety net in recovery from psychosis: a therapist's story. *Hosp Community Psychiatry* 1996;47:69-70.
15. Dorman D. *Dante's Cure*. New York, Other Press, 2004.
16. Prince RH. Religious experience and psychopathology: Cross-cultural perspectives. In: Schumacher JF (ed). *Religion and Mental Health*. New York, Oxford University Press, 1992, pp 281-290.
17. Halifax J. *Shamanic Voices: A Survey of Visionary Narratives*. New York, Dutton, 1979.
18. Epstein M, Topgay S. Mind and mental disorders in Tibetan medicine. *Revision* 1982;5:67-79.
19. Caplan M. *Halfway Up the Mountain: The Error of Premature Claims to Enlightenment*. Prescott, Hohm Press, 1999.
20. Buckley P. Mystical experience and schizophrenia. *Schizophr Bull* 1981; 7:516-521.
21. James W. *The Varieties of Religious Experience*. New York, New American Library of World Literature, 1958.
22. Arieti S. *Creativity: The Magic Synthesis*. New York, Basic Books, 1976.
23. Newberg A, D'Aquili E, Rause R. *Why God Won't Go Away: Brain Science and the Biology of Belief*. New York, Ballantine Books, 2001.
24. Mills N. The experience of fragmentation in psychosis: can mindfulness help? In: Clarke I (ed). *Psychosis and Spirituality: Exploring the New Frontier*. London, Whurr Publishers, 2001, pp 222-235.
25. Dodds ER. *The Greeks and the Irrational*. Berkeley, University of California Press, 1951.
26. Leuder I, Thomas P. *Voices of Reason, Voices of Insanity: Studies of Verbal Hallucinations*. Philadelphia, Routledge, 2000.
27. American Psychiatric Association. *Diagnostic and Statistical Manual*, 4th ed. Washington, DC, American Psychiatric Association, 1994.
28. Lata J. *Visual Hallucinations in Hispanic Clinic Patients: A Need to Assess for Cultural Beliefs*. Carlos Albizu University, 2005.
29. Posey TB, Losch ME. Auditory hallucinations of hearing voices in 375 normal subjects. *Imagination, Cognition and Personality* 1983;3:99-113.
30. Barret TR, Etheridge JB. Verbal hallucinations in normals. I: People who hear voices. *Appl Cogn Psychol* 1992;6:379-387.
31. Forrer GR. Benign auditory and visual hallucinations. *Arch Gen Psychiatry* 1960;3:95-98.
32. Liester M. Inner voices: distinguishing transcendent and pathological characteristics. *Journal of Transpersonal Psychology* 1996;28.
33. Heery M. Inner voice experiences: an exploratory study of thirty cases. *Journal of Transpersonal Psychology* 1989;21:73-82.
34. Peters ER, Joseph S, Garety PA. Measurement of delusional ideation in the normal population: introducing the PDI (Peters et al. Delusions Inventory). *Schizophr Bull* 1999;25:553-576.
35. Jackson MC, Fulford KW. Spiritual experience and psychopathology. *Philos Psychiatr Psychol* 1997;1:41-65.
36. Lukoff D. Transpersonal psychotherapy with psychotic disorders and spiritual emergencies with psychotic features. In: Scotton B, Chinen A, Chinen A (eds). *Textbook of Transpersonal Psychiatry and Psychology*. New York, BasicBooks, 1996.
37. Lukoff D. Divine madness: shamanistic initiatory crisis and psychosis. *Shaman's Drum* 1991;22:24-29.

38. Greenberg D, Witztum E, Buchbinder J. Mysticism and psychosis: the fate of Ben Zoma. *Br J Med Psychol* 1992;65:223–235.
39. Brett C. Psychotic and mystical states of being: connections and distinctions *Philos Psychiatr Psychol* 2002;9:321.
40. Maher BA. *Delusions as the Product of Normal Cognitions*. New York, John Wiley & Sons, 1988.
41. Alloy LB, Tabachnik N. Assessment of covariation by humans and animals: the joint influence of prior expectations and current situational information. *Psychol Rev* 1984;91:112–149.
42. Peters E. *Are Delusions on a Continuum? The Case of Religious and Delusional Beliefs*. London, Whurr, 2001.
43. Saver JL, Rabin J. The neural substrates of religious experience. *Journal of Neuropsychiatry and Clinical Neurosciences* 1997;9:498–510.
44. Kirkness B (ed). *Target Schizophrenia*. London, National Schizophrenia Fellowship, 1997.
45. Jackson M. Psychotic and spiritual experience: a case study comparison. In: Clarke I (ed). *Psychosis and Spirituality: Exploring the New Frontier*. London, Whurr Publishers, 2001, pp 165–190.
46. Lukoff D, Lu F, Turner R. Toward a more culturally sensitive DSM-IV. Psychoreligious and psychospiritual problems. *J Nerv Ment Dis* 1992; 180:673–682.
47. Lukoff D, Lu F, Turner R. From spiritual emergency to spiritual problem: The transpersonal roots of the new DSM-IV Category. *Journal of Humanistic Psychology* 1998;38:21–50.
48. Greenberg D, Witztum E. Problems in the treatment of religious patients. *Am J Psychother* 1991;45:554–565.
49. Agosin T. Psychosis, dreams and mysticism in the clinical domain. In: Halligan F, Shea J (eds). *The Fires of Desire*. New York, Crossroad, 1992.
50. Ritsher J, Lucksted A, Otilingam P. Hearing voices: explanations and implications. *Psychiatr Rehabil J* 2004;27:219–227.
51. Cardena E, Lynn SJ, Krippner SC (eds). *Varieties of Anomalous Experience: Examining the Scientific Evidence*. Washington, DC, American Psychological Association, 2000.
52. Turner R, Lukoff D, Barnhouse R, et al. Religious or spiritual problem. A culturally sensitive diagnostic category in the DSM-IV. *J Nerv Ment Dis* 1995;183:435–444.
53. Harder S. Self-image and outcome in first-episode psychosis. *Clin Psychol Psychother* 2006;13:285–296.
54. Startup M, Wilding N, Startup S. Patient treatment adherence in cognitive behaviour therapy for acute psychosis: the role of recovery style and working alliance. *Behavioural and Cognitive Psychotherapy* 2006;34: 191–199.
55. Estroff SE. *Making It Crazy: An Ethnography of Psychiatric Clients in an American Community*. Berkeley, University of California Press, 1981, p 223.
56. Jung CG. *The Psychogenesis of Mental Disease*. Princeton, Princeton University Press, 1960.
57. Iancu I, Dannon PN, Ziv R, et al. A follow-up study of patients with DSM-IV schizophreniform disorder. *Can J Psychiatry* 2002;47:58–60.
58. Arieti S, Schreiber FR. Multiple murders of a schizophrenic patient. *J Am Acad Psychoanal* 1981;9:501–524.
59. Perry J. Mental breakdown as a healing process. Available at: <http://www.global-vision.org/interview/perry.html>. Accessed April 24, 2003.
60. Mosher L, Menn A. Soteria: An alternative to hospitalization. In: Lamb HR (ed). *Alternatives to Acute Hospitalization*. San Francisco, Jossey-Bass, 1979, pp 73–84.
61. Kornfield J. *A Path with Heart: A Guide Through the Perils and Promises of Spiritual Life*. New York, Bantam Books, 1993.
62. Cortright B. *Psychotherapy and Spirit: Theory and Practice in Transpersonal Psychotherapy*. Albany, SUNY Press, 1997.
63. Lindner R. The jet-propelled couch. In: Lindner R (ed). *The Fifty Minute Hour*. New York, Holt, Rinehart and Winston, 1954.
64. Victor B. Psychopharmacology and transpersonal psychology. In: Scotton B, Chinen A, Battista J (eds). *Textbook of Transpersonal Psychiatry and Psychology*. New York, Basic Books, 1995, pp 327–334, 332.
65. Gallup G. *The Gallup Poll: Public Opinion 1986*. Wilmington, Scholarly Resources, 1987.
66. Hillman J. *Healing Fiction*. New York, Station Hill Press, 1983, p 10.