The Diagnostic Separation of Psychosis and Spiritual Experience II:

Distinctive Criteria for Clinical Practice[1]

E. W. Harnack

You are still here! This is unheard-of, on my word!
Vanish! We brought enlightenment as you have heard!
This devilish crew cares not for rules or books.
We are so wise, and yet in Tegel there are spooks!

Goethe, Faust I, Walpurgis Night
(translated by George Madison Priest)

Abstract

While in the first part of this article (JSTP, Issue 3, 2011) the foundations were laid for stating without Peitio principii what is psychosis (and what is not), this article aims to explain on this basis how spiritual experiences can be identified as non-pathological, exceptional experiences. The emphasis here is on the formulation of more specific criteria, appropriate for the practice of the psychological counsellor, physician, or psychotherapist, to distinguish spiritual from pathological elements of an experience. The appendix of this article contains a here for the first time published interview, the DIAPS (Diagnostic Interview for the Assignment of Pathologic and Spiritual experiences), which will provide the practitioner with such an instrument.

Keywords: Psychosis, psychopathology and spiritual experience, diagnostics, interview, DIAPS

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[1] This article is dedicated to the unwearied protagonist of a diagnostics that recognizes spirituality as such, Prof. Dr. Christian Scharfetter.

Introduction

If you expect that the human psyche is both expression of individual being-in-the-world and as such prone to internal conflicts and disturbances, but also can stand in correspondence with a higher, transcendent reality, you need to know how both sides relate to each other. How can their relationship be determined in someone who is in a severe crisis, experiencing unusual, unbelievable things? Can those aspects that emerged due to his/her conditions of individuation[2] be separated as possibly pathologically from those aspects of his/her experience coming from its supra-individual, spiritual mind? Is it not true that every person because of his/her super-naturalistic origin bears the spiritual dimension within him-/herself and also that many people posses psychologically immature parts, which may interfere with their spiritual and mental clarity. If we want to distinguish spiritual experience from severe forms of pathological derailment, particularly the psychoses, we must get at least one of the two components clearly into view, so we know when it is present. So if we have an ideologically neutral, not by anti-spiritualism coloured criterion of when psychosis is present, then we also know when it is absent and a seemingly odd experience must be explained differently (where it remains open whether we accept a spiritual explanation for it or not). Therefore, in the first part (Harnack, 2011a) we have already tried to define the concept of psychosis as detailed as possible, which can come easier into consideration than its point of contrast, the spiritual crisis or extraordinary spiritual experience. From its certain presence or absence, the existence of the second category of our process of elimination can be assumed.

As we have seen in the first part, a definition of psychosis being valid in different cultures, subcultures and under different social conditions only can be a very concentrated essential definition. It is important to find a transculturally valid concept of psychosis, because we live in a society with a strong anti-spiritual bias, which in contrast to other cultures is not able to separate between psychosis and spirituality. Other cultures, however, are and were clearly aware of this difference and did not confuse, as we often assume, psychosis with spiritual experience. It is our culture that without differentiation confused spiritual experience with psychosis. This is confirmed by studies showing that the supposed cultural independence and objectivity of the classification of potential psychoses is not given. Fenton et al. (1981) summarize the study data in the way that "at least nine non-illness-related factors [...] have been shown to influence the as-

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[2] Individuation not meant in the sense of Jung, but as that process in which the prenatal mind by coming-in-this-world is equipped with body/disposition and socialization, and thus is becoming an individual.

sessment of psychopathology – for example race, sex, socioeconomic status, context, theoretical views, type of interview, and religious and political beliefs of the patient" (452). An essential definition of psychosis, we have seen in the first part, cannot rely on the *contents* of thoughts (e.g., delusional thoughts), and perceptions (e.g., hallucinations), but only on the *form*. We have seen that a psychotic mode of consciousness *function* exists, and that it is dysfunctional by a preponderance of personal processes, originating from the individual unconscious (not from a supra-individual sphere).

As the most typical feature of psychosis, we have considered delusion, in order to realize that even in this, classically known as a "thought disorder of content" not the content of thought but the thought process itself has to be viewed as defective. Even more this is true of the perception disorders and the formal thought disorders, where it is never *what* the other person perceives or what s/he expresses, but *how* their perception and thinking function what makes it dysfunctional and thus a psychosis. If we do not accept this, then we fall prey to circular reasoning: An exceptional human experience (EHE) is psychotic, if and only if its contents are exceptional (i.e., deviating from norm). As this feature applies to any extraordinary experience, the following is true: Any exceptional human experience is pathological (If [EHE = EHE] $\Rightarrow$ [EHE = psychotic] $\Rightarrow$ [All EHE are pathological]). This apparent tautology, however, is certainly the basis for many clinical diagnoses. In my opinion, Jackson's and Fulford's (1997) view, as discussed in the first paper (Harnack 2011a), is so confusing because the authors assume that any spiritual experience would take place only in the subject, what results in the assumption of a non-pathological, *but psychotic* state. For clarity, we should assume that a non-pathological condition could not be described as psychotic. From this base, the contents of thought and perception can be as rare and strange, they remain always possible as a reality as long as they are not disturbed in the formal sense and in the overall context. Whether we accept that as a non-pathological and therefore non-psychotic reality *within* the subject or as an actual and external reality *beyond* our ordinary senses and imagination remains to be seen.

According to today's psychopathology and following what has been said in the first part of this paper, some basic principles can be derived, which help us to know if we may designate a human condition to be mentally disturbed or unhealthy:

1) *Being a syndrome:* A symptom is not yet a syndrome (e.g., hearing voices as isolated symptom without other impairments, which occurs as often as hear-

ing voices within psychoses, is not a psychosis itself). Only a combination of "pathological" features indicates mental disorder.

2) *Psychological strain:* A disorder that disturbs nobody (other than the assessor) is not a disorder (for example, a well-compensated and integrated isolated hearing of voices).
3) *The criterion of formal disorder in the case of psychosis:* Content can only be called disturbed if the form of thoughts is disturbed. In other words: delusions are formal thought disorder, or they are not (such as an socially not acceptable assumption that is emotionally inadequately charged and cannot be questioned rationally, is defined as delusional by the two formal criteria mentioned. And the assumption of being guided by angels is not delusional if such criteria are missing).
4) *Control:* Voluntarily inducing (and being able to leave) a state (i.e., an almost completely preserved ability to control those states) excludes that there is disorder (such as in the deliberately induced ecstatic trance, in which alien beings are "hallucinated"). Conversely, the fact that a state occurs spontaneously means only that it is a disorder if the other criteria for a disorder are met (e.g., the occurrence of uncontrollable feelings of happiness at the sight of a loved one, the uncontrollable grief at the loss of such a person are not a pathological condition, yet they are sometimes perceived as uncontrollable).

In the following, the distinction between psychosis and spiritual experience shall be extended to the consideration of the second part of this contrasting pair of terms: The spiritual experience itself shall come into view and be detected in its difference to what we have defined as psychosis on the basis of empirical findings from the scientific literature and multiple clinical experiences. So we could conclude that a psychotic process is present (P +), but have thus not yet decided whether additional spiritual elements are involved (S +) or not (S-), as long as we have not formulated any criteria for the existence of spiritual states. Only when we conceptualize both as mutually exclusive, the presence of psychotic elements (P +) can be equated with the exclusion of spiritual elements (P+ $\Rightarrow$ S-). But even then, the impossibility of diagnosing a psychosis, according to our strict definition (i.e., P-), would still not give sufficient reason to hold an extraordinary experience for a spiritual one (S+). Therefore, we will look at some criteria systems that go beyond the definition of psychosis and undertook to describe spiritual elements in psychotic states (e.g., Lukoff 1985, Jackson & Fulford, 1997), or in distinction of the one from the other (e.g., Scharfetter 2004). At the end of this journey through various bilateral delimitations, a list of criteria will be presented as a summary of those distinctions, which will facilitate the practitioner's as-

sessment. However, a distinction between pathological and spiritual processes is not possible without presuppositions, which enter into any such characterization: Are there any spiritual processes sui generis? Or the other way around: Are there any pathological processes without regarding context variables? Systemic and social constructivist epistemologies contradict the existence of such context-free truths. The question of a distinction between psychosis and spiritual experience is always based on a worldview that allows for both possibilities in principle. It only makes sense to distinguish the two aspects, if neither the existence of a spiritual reality nor the occurrence of pathological mental states is principally denied.

Criteriologies

Can we really distinguish psychosis and spiritual experience based on the main criterion of formal thought disorder? Some researchers seem to confirm this. Buckley (1981) found in single case and literature studies, in which he compared mystical and psychotic pre-classified individuals, that only psychotic states were associated with disorders of formal thinking: "Thought blocking and other disturbances in language and speech do not appear to accompany the mystical experience" (Buckley 1981, 521). In other respects, however, similarities between mystical and psychotic states of consciousness appeared: a powerful impression of super-naturalistic knowledge ("noesis"), an expansion of perception, the sense of community and close encounter with the divine, and an elevated mood state existed in both populations. Does this mean that psychotic and spiritual processes can be separated or is there an intersection of features that account for both psychotic and spiritual experiences?

Lukoff (1985, 169ff.) does not separate psychosis from spiritual crisis in his DSM-compatible syndrome draft, but sees, similar as Jackson and Fulford (1997), spiritual elements in psychotic states. The genuine psychoses are psychotic states with a difficult course and without any real spiritual elements (for example, typical schizophrenia), on the other hand there are mixed states of mystical and psychotic elements. Such "mystical experiences with psychotic features" differ from ordinary psychoses by three main elements: (1) Overlap with mystical experience: (a) ecstatic mood, (b) a sense of new knowledge, (c) perceptual alterations ("ranging from heightened sensations to auditory and visual hallucinations with religious content"), (d) delusions (if any) have mythological references, (e) no conceptual disorganization. (2) A positive result is likely and this is reflected by at least two of the following indications: (a) a good level of function-

ing before the episode as indicated by the lack of previous psychotic episodes, the existence of a social network, of intimate relationships and success in vocational training, (b) an acute onset of symptoms during a period of 3 months or less, (c) stressful events before the psychotic episode, such as major life changes or development passages, e.g., from adolescence to adulthood, (d) a positive, interested attitude toward the experience as important, including revelations and growth. (3) There is a low risk of acute self- and other-endangering behaviour. For Lukoff, even a psychotic derailment under the influence of archetypal structures of the collective unconsciousness and of mystical contact with transcendence can take a favourable course, includes growth and development potential. But his conception seems not helpful for the clinician to distinguish with certainty between psychotic and spiritual elements.

Jackson, probably looking empirically at the same intersection of psychosis and spiritual experience as Lukoff, makes a similar observation (2001, see also 1990) but tends to generalize this intersection to all spiritual crises. He remarks on his comparison between a group diagnosed with psychosis and another one not classified as pathologic (both with spiritual elements): "The differences between the experiences described in the two groups were most apparent in their short-term effects in the individual's lives. The undiagnosed group felt empowered and helped by their experiences, where the diagnosed subjects were overwhelmed and isolated by theirs" (183). In line with James (1902), Jackson (2001) found more negatively toned spiritual experience in the psychotic diagnosed group, while the not as such diagnosed group reported more positive experiences. However, the distinction blurred in the medium term, as in Jackson's sample, which was selected specifically because of their spiritual features, also the pure psychotics "in the longer term [...] regarded their psychoses as part of a process through which they reached [...] a constructive spiritual reorientation " (183). In other distinguishing criteria, he also found demonstrated, according to him, that a clear distinction between psychosis and spiritual experience is not possible. This result is most certainly a problem of sample selection: it seems little purposeful to regard cases that are very difficult to assign as representative for the entire population of spiritual crises or psychotics.

Scharfetter (2004, 123f.), in contrast, separates mystical and psychotic experiences very decidedly, emphasising that according to his clinical experience and judgment an intersection or mixed category was rare. A key criterion for him is that of dysfunction or "infirmity" of pathological states: "Disease means 'infirmity': i.e., that a person through life events, experiences, changes becomes dysfunctional, is not able to manage his life tasks any more and therefore needs help" (124; my translation). If, on the other hand, there is an experience, how

extraordinary so ever, that does not to lead into "infirmity" or dysfunctionality it is not possible to speak of illness and of psychosis. To assess the status of being a disorder, the biographical background and actual life situation have to be included, the "context of the entire form of experiencing and behaviour (syndrome), especially regarding the consequences for functioning of the basic living needs (reality-examination, self-control, etc.)" (123; my translation). A diagnosis separated from the context, which usurps the experience instate of reflecting the life context of the experiencing person as a whole must therefore inevitably lead to false positives. For theoretical justification of his discrimination Scharfetter uses the concept of consciousness, where the (according to depth psychology) subconscious is distinguished from a (spiritual, collective, etc.) super-consciousness and from the normal waking consciousness. "There is no pathology of the subconsciousness and not of the super-consciousness. Psychopathology means dysfunction in the waking consciousness" (123; my translation). Spiritual phenomena may appear as strange as they want; as long as they have their origin in the genuine super-consciousness they are never pathological.

An empirically tested and standardized survey methodology of exceptional experiences was created as Transpersonale-Erfahrungen-Inventar (transpersonal experiences inventory; see Kohl 2004). In it, the following items have proven to provide the sharpest separation between clinical and spiritual populations (items in italics = formulation in direction of spiritual population; formulation in favor of psychosis are in normal typeface, Kohl 2004, 420; my translation): "*I know my vocation; I am reconciled with everything; Inside my spine something like energy flows upwards (e.g., like a stream of fluid or light); Spiritual forces inspire my work; I assist people who are in need in my mind and thus can help them.* – My will is active without me, as if it would be driven from elsewhere; My thoughts are changed by an external force; I can not follow my thoughts anymore; Foreign powers control me; I'm obsessed by an idea and cannot stop thinking about it". In a factor analysis, moreover, the following items form a common pathological factor (at a 4-factor solution, Kohl 2004, 432; my translation): "I hear clearly – for no apparent external stimulus – voices insulting me or making fun of me; I am cursed; Foreign forces control me; Others read or hear my thoughts; A strong foreign power absorbs my body; Some thoughts strike me as strange, as if it were not my own; I'll send someone, whom I want to harm, misfortune by my thoughts". Note that most of these pathological items are covered by the four main criteria of pathological conditions mentioned above.

However, as other approaches presented here, the inventory relies insofar on a *petitio principii* as its key concepts of pathology and spirituality are not cleared

in advance: preconceptions about the nature of these terms are mixed into the selection of samples (the allocation as psychotic or spiritual). The circularity hidden herein is widespread in the social sciences. In the same way, the well-known early diagnostic tool of schizophrenic disorders SOPS (McGlashan et al 2001) suffers from a theoretical appeal to unquestioned principles: the examiner shall, by the will of the authors, beware of evaluating extraordinary content per se as psychotic (what the examiner may, unfortunately, often forget), but beforehand he must have an implicit criterion for psychosis in order to assess whether the participant responds psychotic. The procedure is useful as a checklist, but renders as epistemic output only what the examiner put already in it. We therefore should recommend to these authors our preliminary clarification of the psychosis concept, as done in the first part of this paper, particularly in light of the developments of modern psychopathology, where an extension of the term psychotic disorder on clinically inconspicuous, potentially "at risk" persons is suggested through the concept of basic disorders and clinical prodromal symptoms (Huber 1995; Klosterkötter et al. 2001, Yung & McGorry, 2007).

The following synopsis is meant to subsume these and other criteria, mentioned by Scharfetter (2004, 125), Grof & Grof (1991, here in the abbreviated version by Helg 2000, 286), Kason (1994, 232), Brunnhuber & Wagner (2006) and Jackson (2001, 170; in his literature review). Some of the listed claims (such as the assumption that for psychiatric disorders organic findings existed, but in spiritual crises they were regularly missing) have to be considered critical, while some are from a certain theoretical (e.g., psychoanalytic) context or focus only on a distinctive form of spiritual crisis. Overall, probably none of the features mentioned here is suitable as the sole criterion of assignment (think again of the principle "one symptom does not make a syndrome").

Spiritual Experience	**Psychopathology**
No organic findings	Organic findings exist[bc]
Process:	
Transient process	Long lasting process [e]
Resulting in spiritual fruits (humility, altruism, creativity)	Resulting in psychic disorder (self-centeredness, disability to function)[e]

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[b] Grof & Grof (1991) in der gekürzten Form nach Helg (2000, 286)
[e] Jackson (2001, 170)

Affect:	
Mood swings	Depressive, manic, or anxious affect [a]
Simultaneity of complementary affects; humility, renunciation, empathy	Mostly isolated patterns of affects with affective peaks (rage, anger, anxiousness)[c]
Relatively adequate emotional reactions	Inadequate emotional reactions[d]
Consciousness:	
Special states of consciousness (en/ekstasis), also depersonalisation and derealisation	Possibly dream like states, depersonalisation, and derealisation[a]
Mechanism:	
(Dis-)Identification, progression	Projection, suppression, splitting, and regression[c]
Ego-Functions/Perceptions:	
Temporary ego-loss, visions, acoustic hallucinations	Ego-disintegration, bad trip, loss of control, hallucinatory experience[a]
Ego-functions stay intact, are provable in biography	...get lost[c]
Pseudo-hallucinations, primarily visual; mood congruent, coherent, friendly	Genuine hallucinations, primarily acoustic; first rank symptoms, chaotic, criticizing[e]
Able to ignore perceived voices	Overpowered by perceived voices[d]
Able to tolerate negative visions	Overpowered by frightening visions[d]
Afraid of losing control	Has lost control[d]
Perceived presence or non-embodied beings are benevolent and well-known	...are malevolent and/or idiosyncratic[e]
Sensation of being guided by higher power, with remaining self control	...without self control[e]
Being challenged by the experience	Overpowered by the experience[d]
Big problems to function	Unable to function[d]

[a] Scharfetter (2004)
[d] Kason (1994, 232)

Problems with making judgements	Unable to make correct judgements[d]
Thought processes are clear	...are incoherent, contain loose associations[d]
Conscious that an inner process is going on	Inner and outer world are mixed up[b]; has paranoid delusional ideas and projects the source of the experience on others[d]
Problems distinguishing inner and outer world	Inability distinguishing inner and outer world [d]
Correctable, plausible convictions with inner capacity of discernment	Uncorrectable, bizarre convictions without inner capacity of discernment[e]
Self: Focussing intrapsychological processes; introversion exceeds extraversion	Interpersonal problems are clinically dominant[c]
Temporary ideas of grandiosity	Delusions of grandeur[d]
Belief in one's own mission with humility and knowing one's defectiveness	...with grandiosity and idea of infallibility[e]
Predisposition: Unstable, non-integrated, segmented personality, false self	Ego-weakness, prone to disintegration, vulnerable[a]
No psychiatric anamnesis	Psychiatric anamnesis[b]
Trigger: Strong desires, attachment, spiritual conflicts / worldly life, typical triggers for altered states of consciousness	Events stressing the ego (including spiritual experiences of opening)[a]
Practice: Expansion of consciousness limited to contemplative practices	...as escape from reality, avoiding problem solving[c]
Themes and contents: Opening to / residing in „higher" transpersonal realms, letting go of attachment to normal waking consciousness, liberation, enlightenment, Unio, salvation	Survival/continuance of the ego, value, rank, importance, power, influence, relation, overcoming loneliness, physical health/integrity, guilt and atonement[a]
Possibly understanding that the process is of a healing or spiritual nature. Emerging	Badly organized and defined process contents. Lack of significance, no direction of

of biographical issues, themes of birth and death	development; loose associations; incoherence[b]
Abstract, general values, questions of meaning	Badly organized; often no development discernable[c]
Moral and ethic values remain intact	Moral and ethic values get lost[d]
Intensive positive emotional experience	Intensive negative emotional experience[e]
Interaction und social environment: Willingness to cooperate, trust, openness	Distrustful, paranoid behaviour[c]
Desire to cooperate and share experiences in therapy	Cooperation in therapy is very difficult, withdrawal or aggression[b]
Trusting others is possible, capacity to accept help, no persecution mania	Strong distrust, possibly persecution mania, acoustic hallucinations with hostile contents[b]
Network of satisfying relations	Life long history of difficult relations[b]
Content of experience is subculturally accepted	...is idiosyncratic, bizarre, alienating[e]
Behaviour: Demonstrating slightly strange behaviour	Demonstrates inadequate behaviour, including externalized destructive behaviour, self-destructive behaviour, disorganized behaviour, fixated compulsions[d]
Good cooperation in respect to physical health	Behaviour endangers physical health[b]
Impulse control: Not endangering self and others	Often endangering self and others[c]
Few auto-destructive tendencies; preventive measures are accepted	Strong destructive and auto-destructive tendencies, tendency to act them out without premonition[b]

Fig. 1: Synopsis for distinction between psychosis and spiritual crisis

Other key criteria

There are other criteria for the distinction between pathological and healthy conditions resulting from these considerations, which seem to have particular relevance for clinical practice and have not yet found adequate evaluation in the refereed literature.

Psychological strain

Let us again remember the four above mentioned main criteria that allow us to assign an experience as being somehow disturbed. We addressed psychological strain as one of those. Actually, we see repeatedly that people, who get on well with their extraordinary experiences and live socially integrated lives, suffering neither subjectively nor objectively, are pathologized by others, mostly professional diagnosticians. So, is it really the subject that is afflicted with the phenomena (i.e., subjectively, or – as is often the case with psychosis – at least objectively, in the sense that such suffering is empathetic understandable from the outside)? Or are the phenomena for him or her even positive and potentially curative, although they may seem unusual and bizarre to other people? Do the symptoms cause the suffering or is it caused by a reaction of the environment? A discrepancy between a subjective experience of the individual and his environment is part of the biographies of many saints (including that of Jesus of Nazareth) and can be a trigger for suffering. But this does not mean that giving up the perspective of the individual in favour of that of the majority would be in any way helpful to end the suffering. The suffering of others is a social phenomenon, and none of psychopathology.

Control

As another one of the four main criteria, the ability to control deserves to be regarded closer, because it says something about clarity of consciousness, the orderliness of the mental system. Does the person have complete control over his or her mental state, partial control or no control at all? For example, can they determine whether they want to hear or see spiritual beings or do they hear voices in the classic psychiatric sense, whether they like it or not? Can they come back from severe psychological states of anxiety or internal activity into outward directed, quieter operations or does this not succeed anymore?

Cross-cultural evidence

In order to assess an extraordinary experience according to the content, trans-cultural experience with spiritual phenomena of thousands of years of human history is available. The materialistic and scientistic culture of the 20th (and hopefully much less the 21st) century in the Western Hemisphere contains no ultimate truth (as a glance at the history of science can teach us), but only a temporary valid perspective. Although in our culture some forms of psychological experience are considered psychotic, in other cultures (in some cases even in *all* cultures except our own) they will be appreciated as evidence for spiritual powers. This is the case for phenomena as the obsession by gods or spirits, which are virtually everywhere on earth seen as a spiritual phenomenon, requiring an appropriate (usually successful) approach, except in materialism-scientism. This also applies to energy related symptoms that have been explored in detail as the rise of Kundalini in India and elsewhere for centuries, but are subsumed in this society under the completely meaningless term psychosis. But what an arrogance becomes obvious when we hold our own understanding to be the most sophisticated in the world, and at the same time even our best scientists cannot differentiate between psychosis and Kundalini syndrome, are not able to explain what psychosis really is, or even to heal it while they devalue the Indian sage, who possibly is capable of all this.

Ability to disidentify with experience

The social psychiatry movement already found it strange to talk about the "incorrigibility of madness": Would it not be much crazier to give up my own perception in favour of the perception of another person? All the more this is true for spiritual processes, in which not worlds of the individual unconscious are perceived, but those of the super-consciousness, not objects of an impaired reality level (purely private reality), but rather those of a higher ontological status (emanating from more than normal reality). In contrast to the person who is trapped in his/her private reality, the one who makes super-naturalistic observations will not lose the social conception of reality at the same time. They will still be able to compare their perceptions with the socially shared reality and understand the expectations of others. Therefore, people with spiritual experiences are generally (if they are not psychotic at the same time) willing to investigate and to

question the reality of their experiences, even experimentally. This ability may culminate in a pronounced ego-dystonia[3] of the experienced.

Ego-dystonia

In many cases where other criteria speak in favour of a spiritual process, ego-dystonia is also observable in intra-psychic processes. While in all psychotic states a distance to the contents of the experience, of thinking and feeling is by definition impossible, in spiritual crises the subjects regularly doubt their own sanity, see their mental state themselves as potentially in need of treatment, although they do not doubt that they experience what they experience. Persons, who suddenly feel energy fields and hidden moods of people, animals and plants, cannot stop the flow of their thoughts or control the *asana* postures their bodies adopt, can be surprised, shocked, and confused by these phenomena (which occur due to an uncontrolled rise of kundalini). They cannot be described as psychotic for that very reason, because psychotic phenomena are always ego-syntonic, while those people are like infested by a contagious disease, hoping for nothing more than a means of healing.

Translatability of unusual use of language

In people who do not fit into the usual social context, we often observe an unusual, idiosyncratic or subcultural use of language (cf. Harnack, 2011b). Such language should be translatable into conventional language, at least when the person concerned is asked and is provided with interpretation assistance. If metaphors and expressions are not translatable any more into a socially shared, conventional language or not classifiable by the subject within a conceptual network, this speaks for a psychosis.

Lack of feeling of weirdness

If the usual structure of reality slips from the individual's hands, in the psychotic mode this causes that the subject initially or permanently experiences a sense of weirdness. "Something" goes on within him or the world, for which he finds no clear explanation. This uncanny feeling of weirdness is then transferred on the diagnostician or emerges in him as well out of the premonition that in the other "something" is not alright, that his thinking and feeling patterns are a little odd,

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[3] *Ego-dystonic* means that for the experiencing person his/her own experiences seem strange and odd (antonym: ego-syntonic).

strange, in a no tangible way different and therefore are somehow scary (scary, because also the counterpart feels the need to draw a line between his/her own mind and the weird thinking of his/her vis-à-vis in order not to lose "reality"). People in serious spiritual crises may be in fear and uncertainty, they may understand the world and their experience no longer, find it all confusing, but they rarely make this impression of subtle weirdness, of which the psychotic sometimes is suggestive.

Lack of emotional charge

That just described feeling of weirdness is partly due to an enormous emotional charge that results from affective-cognitive complexes. This charge can also be found in serious spiritual crises, but it usually does not affect the person's complete cognitive functioning. Psychotic functioning persons do not have the capability of spontaneously structuring the affective-cognitive complex that is always the basis of our experience (cf. Ciompi 1994). On the other hand, individuals that are overpowered by paranormal and spiritual experiences charge the objects of their experience with great significance, too, but they can still use their minds without emotional charge and regard and evaluate that part of the external world, which is not affected by the unusual perceptions.

Undisturbed interpersonal contact

What Bleuler called "autism" in schizophrenia generally points to the difficulty of psychotic functioning persons to get into open, emotionally oscillating relationships with others. Psychotic functioning persons may partially not be able to recognize the inadequate or at least socially differing nature of their perceptions and thought, and therefore get into discrepancies with their environment. Difficult is the distinction between (megalomaniac) psychosis and narcissistic charging of a paranormal event, if the experience is used to form the relationship, for example, in the sense that one's greatness is emphasized, supremacy over the diagnostician and all others is justified by one's own experiences, or others are even threatened aggressively with one's own magical power.

Verifiability

Finally yet importantly, an impartial assessor should try to check any paranormal claims on their reality or at least plausibility. If a client, for example, claims to

have prophetic dreams, it is worthwhile to reclaim his dreams as a daily log by email in order to consider together whether they came true. It generally pays to check the plausibility of psychic and spiritual claims instead of believing them unquestioned or denouncing them as nonsense. As already explained, claims of paranormal experiences do not constitute in themselves a symptom of psychosis. They are, like any other claim, only to be evaluated as wrong and potentially psychotic (or just fantasizing, etc.) if they according to an examination in a particular case do not correspond with reality.

Proposal of a weighted criteria list as diagnostic interview (DIAPS)

As we have seen when we formulated the four principles of psychopathological diagnosis, psychosis is a syndromic construct that is formed by the sum of individual symptoms, not a single symptom. In addition, some features indicate the presence or absence of psychotic elements or a predominantly psychotic process stronger than others do. If we want to create a checklist based on the before described criteria, symptoms must be weighted a priori. After that, the extent of their occurrence in individual cases can be weighted (rated) by the diagnostician.

The author has composed a corresponding list of criteria as a diagnostic interview (Diagnostic Interview for the Assignment of Pathologic and Spiritual experiences; DIAPS). In it, all items have been assigned either to the psychotic or to the nonpsychotic, i.e.: spiritual dimension. The assignment was mainly based on the criteria discussed above, with the leading criterion being: What is known as a spiritual phenomenon in cross-cultural comparison is judged this way, but not those modes of experience that appear (everywhere) as pathological. Therefore, phenomena that are not accepted in our dominant culture can nevertheless appear as non-pathological and be assigned to the spiritual dimension - for example claims, which for many contemporaries seem unbelievable like hovering over the floor (levitation) or refraining from drinking and eating for month (both of which were in the West as in the East stated by holy persons).

The dimensions are constructed in such a way that items of the dimension S (spiritual experience) are very untypical for psychotic functioning, but are typical for spiritual experiences and vice versa with dimension P (pathologic). In addition, items that form part of the diagnostically important Kundalini syndrome score on a separate dimension (K). The affiliation with the respective dimensions is weighted by a multiplier specified a priori, the diagnostician additionally weights the occurrence of the items, so that a tentative quantitative evaluation may be possible. Because empirical testing is so far lacking, quantitative result,

however, should never be considered as a psychological test, but only as a guideline. The procedure is designed as an assessment by others, as some questions of course cannot be answered by the individuals themselves but only from the outside by precise observation of a diagnostician that is experienced and familiar with the principles of distinguishing psychotic and spiritual phenomena. Thus, the questionnaire is not submitted to the client, but read out and filled in by the investigator. It is printed in the appendix to this article. The author is grateful for collegial feedback and advice on the applicability of the interview.

Literature:

Buckley, Peter (1981): Mystical experience and schizophrenia. *Schizophrenia Bulletin 7 (3), 516-521*

Brunnhuber, Stefan & Wagner, R. (2006): Zur Differentialdiagnostik spiritueller Krisen. *Transpersonale Psychologie und Psychotherapie, 12 (1), 34-44.*

Ciompi, Luc (1982): *Affektlogik*. Stuttgart: Klett-Cotta.

Crowley, Nicki (2006): *Psychosis or Spiritual Emergence? - Consideration of the Transpersonal Perspective within Psychiatry*. Public speech: The Royal College of Psychiatrists, London - Spirituality and Psychiatry Special Interest Group Meeting 31st March 2006.

Dittrich, A., S. von Arx, & S, Staub. 1985. International study on altered states of consciousness (SASC). Summary of the results. *German Journal of Psychology 9, 319-339*

Fenton, W. S., L. R. Mosher, and S. M. Matthews (1981): Diagnosis of schizophrenia: A critical review of current diagnostic systems. *Schizophrenia Bulletin* 7 (3), 452-476.

Goretzki, Monika (2007): *The differentiation of psychosis and spiritual experience. Doc. thesis.* University of Adelaide.

Grof, Stan & Grof, Christina (1991): *Die stürmische Suche nach dem Selbst. Praktische Hilfen für spirituelle Krisen.* München: Kösel.

Harnack, E. W. (2011a): Die diagnostische Trennung von Psychose und spiritueller Erfahrung I: Das phänomenologische Wesen der Psychose. *ZSTP 1 (3), 342-361.*

Harnack, E. W. (2011a): Der Preis des Andersseins: Schizotypie, hyperpermeables Ich und gesellschaftliche Reaktionen auf spirituelles Erleben. *ZSTP 1 (2), 215-228*

Hartley, Janice & Daniels, Michael (2008): A grounded theory investigation into negative paranormal or spiritual experience, based on the 'diabolical mysticism' of William James. *Transpersonal Psychology Review 12 (1), 51-72.*

Helg, Felix (2000): *Psychotherapie und Spiritualität. Östliche und westliche Wege zum Selbst.* Düsseldorf: Walter.

Huber Gerd (1995): Prodrome der Schizophrenie. *Fortschritte der Neurologie, Psychiatrie 63,131-138.*

Irwin, H. & C. Watt. 2007. *An Introduction to Parapsychology*. Jefferson: McFarland.

Jackson, Michael (1990): *Religious experience and psychoses.* Vortrag, gehalten vor der Alister Hardy, London (publiziert als Tonband-Kassette).

Jackson, Mike & Fulford, K. W. M. (1997): Spiritual experience and psychopathology. *Philosophy, Psychiatry, & Psychology, 4 (1), 41-65*

Jackson, Mike (2001): Psychotic and spiritual experience: a case study comparison. In Isabel Clarke (ed.): *Psychosis and spirituality. Exploring the new frontier.* 165 – 190. London: Whurr.

James, William (1902): *The Varieties of Religious Experience: A Study in Human Nature*, Being the Clifford Lectures on Natural Religion delivered at Edinburgh in 1901–1902. London & Bombay: Longmans, Green, and Co.

Kason, Yvonne & Degler, Teri (1994): *A farher shore. How near-death and other extraordinary experiences can change ordinary lives.* Toronto: Harper Collins.

Klosterkötter, Joachim; Hellmich, Martin; Steinmeyer, Eckhard M.; Schultze-Lutter, Frauke (2001): Diagnosing schizophrenia in the initial prodromal phase. *Archives of General Psychiatry 58 (2), 158-64.*

Kohls, Nico B. (2004): *Außergewöhnliche Erfahrungen – Blinder Fleck der Psychologie?* Münster: LIT.

Lukoff, David (1985): The diagnosis of mystical experiences with psychotic features. *Journal of Transpersonal Psychology 17 (2), 155–181.*

McGhee, M. 2003. Mysticism and psychosis: Descriptions and distinctions. *Philosophy, Psychiatry & Psychology* 9, no. 4:343-347.

McGlashan, T. H.; Miller, T. J.; Woods, S. W.; Hoffman, R. E.; and Davidson, L. 2001. A scale for the assessment of prodromal symptoms and states. In: Miller, T.J.; Mednick, S. A.; McGlashan, T. H.; Liberger, J.; and Johannessen, J. O., eds. *Early Intervention in Psychotic Disorders.* Dordrecht: Kluwer Academic Publishers. 135-149.

Scharfetter, Christian (1997): *Der spirituelle Weg und seine Gefahren.* Stuttgart: Enke

Scharfetter, Christian (2004): *Das Ich auf dem spirituellen Weg*. Vom Egozentrismus zum Kosmozentrismus. Sternenfels: Verlag Wissenschaft & Praxis.

Yung, A. R. & P. D. McGorry (2007): Prediction of psychosis: Setting the stage. *British Journal of Psychiatry* 191, suppl. 51, s1-s8.

Zahavi, David (2008): Phenomenology. In D. Moran (ed.): *The Routledge Companion to the 20th century philosophy*. London: Routledge.

About the author:

The author is editor of JSTP and works as psychologist in Berlin/Germany. Contact: edgar.harnack[at]gmail.com