Journal of Humanistic Psychology
Volume 48 Number 4
October 2008 505-527
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10.1177/0022167808314174
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Enlightened or Delusional?

Differentiating Religious, Spiritual, and Transpersonal Experiences from Psychopathology

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Psychological diagnosis faces unique challenges when used to differentiate nonpsychopathological religious/spiritual/transpersonal (R/S/T) experiences from those that might evidence psychopathology, particularly considering the diversity of such experiences and the value-laden assumptions inherent in most diagnostic practices. Theoretical and pragmatic problems related to the diagnostic category, Religious and Spiritual Problem, as contained in the *Diagnostic and Statistical Manual of Mental Disorders* are discussed. Attention is paid to identifying potential biases and errors in using, or failing to use, this diagnostic category, particularly as related to developing culturally sensitive diagnoses. Specific methods, including psychometric approaches, for evaluating R/S/T experiences that may range from healthy to psychopathological are reviewed and recommendations are presented for improving current diagnostic practices and furthering needed research.

Keywords: *religion; spirituality; transpersonal; diagnosis; DSM-IV; psychopathology*

Perhaps one of the most perplexing arenas for fostering potential biases and subsequent misuse of psychological diagnosis involves religious, spiritual, and transpersonal (R/S/T) experiences that may appear as evidence of psychopathology to unaware clinicians. For example, Fukuyama and Sevig (1999) emphasized how cultural context can vastly shift a diagnosis in this area. Claims that one has encountered a vision of the Virgin Mary may be acceptable (and even socially desirable) in some predominantly Catholic Latin American cultures, while claims of being possessed by a spiritual entity may be highly rewarded in the context of Haitian

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voodoo trance dance. However, in most U.S. psychological contexts, both these claims would likely be denigrated as mere delusions or hallucinations and used diagnostically as an indicator of psychopathology. In sum, determining whether a client is experiencing enlightenment (i.e., transformative spiritual experience) or delusion (i.e., psychological disturbance) can be wrought with challenges.

There are many studies suggesting that psychological diagnostic practices are unavoidably value laden, subjective, and influenced by clinicians' previous assumptions—that is, they are inherently subject to bias. James and Haley (1995) found that therapists diagnosed clients in poor physical health as more pathological, less appropriate for psychotherapy, and less capable of establishing a beneficial therapeutic relationship than clients in better physical health; they also demonstrated similar biases related to client age. Other studies on diagnosis and clinical judgment have found that client gender (Seem & Johnson, 1998), therapist gender (Hansen & Reekie, 1990), therapists' theoretical orientation and years of clinical experience (Daleiden, Chorpita, Kollins, & Drabman, 1999), and therapists' ethnicity (Atkinson et al., 1996) all affect clinicians' attributions of pathology, including ratings of severity and type of diagnosis, as well as judgments of prognosis. And these are just a few of the many research strands supporting that diagnosis is far from an objective activity. Consequently, for these and many other reasons, humanistic psychologists have been prone to reject or minimize the importance of diagnostic practices (e.g., Honos-Webb & Leitner, 2001; Siebert, 2000), though some have defended the continued use of diagnosis within humanistic psychology despite also recognizing it inevitably involves numerous limitations that can be seen as biases (Friedman & MacDonald, 2006).

However, humanistic psychologists may be somewhat less likely to exhibit such biases toward R/S/T experiences than would other psychologists. For example, Allman, De La Roche, Elkins, and Weathers (1992) surveyed 286 APA psychologists' attitudes toward clients who report mystical experiences. Humanistic psychologists were less likely to consider clients with mystical experiences as psychotic than behavioral, cognitive, and psychodynamic psychologists. Moreover, psychologists who rated spirituality as important were less likely to regard clients' mystical experiences as simply evidence of psychopathology. Taken as a whole, it appears that psychological practices in differential diagnosis of R/S/T problems are especially problematic, but that humanistic psychologists may be more open to these experiences than psychologists from other orientations.

Nevertheless, many mainstream researchers, practitioners, and theorists have recognized the importance of including R/S/T variables in

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diagnostic clinical work (e.g., Cashwell & Young, 2005; Chirban, 2001; Johnson, Hayes, & Wade, 2007; Sperry & Shafranske, 2005), as have some humanistic psychologists (e.g., Friedman & MacDonald, 1997, 2002). The pertinent question is clearly not whether clinicians should assess these variables, but why mental health professionals do not consistently do this.

A Word on Religion, Spirituality, and Transpersonality

Many have argued that the terms *religiosity* and *spirituality* have quite different meanings, though they are frequently used in overlapping ways (e.g., Ho & Ho, 2007). Pappas and Friedman (in press) have conceptually delineated not only these two terms, but also *transpersonality*, as three categories that have distinctly important, though still overlapping, meanings. For consistency of expression, R/S/T will be used as an overarching term encompassing experiences having either a religious, spiritual, and/or transpersonal nature. However, when a researcher or theorist specifically uses only one or two of these terms without the overarching meaning seemingly being implied, the more narrow term or terms are kept for consistency with the original author's intent.

Differentiating among Four Religious and Spiritual Categories

The DSM-IV (APA, 1994) category "Religious or Spiritual Problem" has increased the options and, potentially, the cultural sensitivity toward diagnosing R/S/T concerns. Now that the field has a legitimate option for categorizing R/S/T problems, it is important for psychologists and other mental health professionals to know how to make this diagnosis and distinguish it from psychopathology, especially considering the iatrogenic harm that may occur from inappropriate diagnoses. For example, clients may feel increasingly isolated and misunderstood when their R/S/T experiences are misdiagnosed and this may lead to adverse outcomes, including blocking any future attempts at help seeking (Bragdon, 1993; Lukoff, Lu, & Turner, 1996). Lukoff, Lu, and Turner (1992, 1996) suggested that the inclusion of this new category requires differentiating among four types of problems: (a) purely religious or spiritual problems, (b) mental disorders with religious or spiritual content, (c) religious or spiritual problem concurrent with mental disorder, and (d) religious or spiritual problems not attributable to a mental disorder.

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Purely religious problems consist of concern over faith and doctrinal matters and should be treated by appropriate clergy. For example, a religious person experiencing distress related to his or her religion's doctrinal view on salvation might consider consulting with clergy first or, if this is too distressing, with a clinician familiar with his or her religion's beliefs. In contrast, they defined purely spiritual problems as involving "conflicts about a person's relationship to the transcendent or [that] arise from a spiritual practice" (Lukoff, Lu, & Turner, 1992, p. 677) that are not associated with institutional forms of religion. Examples of this type include a person who has an unusual perceptual experience while meditating or has questions about proper yoga technique. Generally, they suggest that knowledgeable spiritual directors or teachers be consulted for these types of problems.

Lukoff et al. (1992) defined mental disorders with religious and spiritual content as identifiable Axis I disorders that manifest religious or spiritual symbols and expressions. These include obsessive-compulsive disorder, manic episodes, and psychotic episodes that possess religious or spiritual content. Imperative in these instances is to differentiate whether these distressful experiences are "true" expressions of R/S/T or the result of underlying pathology.

Lukoff et al. (1996) created an additional classification called religious or spiritual problem concurrent with mental disorder that involves religious or spiritual problems that are addressed in conjunction with an existing mental disorder. For example, if a therapist addresses excessive religious rituals associated with obsessive-compulsive disorder (OCD), then they argue that both OCD and Religious or Spiritual Problem should be coded. This classification may increase the use of the new category and accentuate the importance of addressing R/S/T issues in mental health. Moreover, this category may alert mental health professionals to the existence of spiritual issues and help focus treatment to address these concerns.

The fourth category, religious or spiritual problem not attributable to mental disorder, refers to experiences directly related to religiosity and spirituality but not psychopathology. Questioning one's religious beliefs and values or distress related to changing one's spiritual community fall under this category as does near-death and mystical experiences (Lukoff et al., 1992). For instance, mystical experiences are among the most frequently encountered spiritual events in the clinical and research literature (e.g., estimates suggest that 30% to 40% of the U.S. population report having had mystical experiences; Hood, Spilka, Hunsberger, & Gorsuch, 1996). Thus, R/S/T experiences are likely typical of normal human experience, rather than being inherently abnormal and indicative of psychopathology (e.g., Johnson & Hayes, 2003).

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Validating the DSM-IV V-Code: Religious and Spiritual Problem

At the current time, only two empirical studies have attempted to validate the utility of the DSM-IV category of Religious or Spiritual Problem using Lukoff et al.'s (1992) criteria. In the first study, Milstein, Midlarsky, Link, Raue, and Bruce (2000) compared clergy and psychologists on their ability to differentially diagnose presenting problems with religious and spiritual content. A national, random sample of 111 rabbis and 90 clinical psychologists (whose theoretical orientations were not identified) were provided three clinical vignettes representing a mental disorder (schizophrenia with spiritual content), a spiritual problem without a mental disorder (mystical experience), and a pure religious problem (client unclear about religious rituals for mourning a parent). They were asked to rate the vignettes as to the likelihood that the situation was caused by spiritual issues rather than psychopathology per se, as well as the severity of the problem and the suitability of psychiatric medication for treating the problem.

Both the clergy and psychologists evaluated the religious etiology of schizophrenia as being less due to religious factors compared to mystical experience, which in turn was attributed less to religious factors compared to mourning a parent. Rabbis considered the etiology of schizophrenia as significantly more due to religious factors than did psychologists. In terms of severity, rabbis rated schizophrenia as more serious than mourning, and mourning more severe than mystical experience. Rabbis also considered mourning a parent as more problematic than psychologists did. In regards to the utility of psychiatric medication, rabbis viewed medication as more useful for schizophrenia than for mystical experience and more helpful for the mystical experience than mourning. Psychologists rated medication as more useful for schizophrenia than both mystical experience and mourning. Psychologists considered medication as significantly more helpful for schizophrenia than the rabbis did.

The validity of these results is limited somewhat by a methodological issue, namely that the vignette for mystical experience did not describe someone who was experiencing overt distress—a vital criterion for diagnosing a religious or spiritual problem. Despite this shortcoming, this study showed that both psychologists and clergy could distinguish among problems with religious and spiritual content. Furthermore, it provided preliminary support for the utility and validity of this distinct category of problems.

In the second empirical study attempting to validate the utility of the DSM-IV V-code for Religious or Spiritual Problem using Lukoff et al.'s

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(1992) criteria, Hartter (1995) surveyed 100 psychologists (60 women and 40 men, 63% of whom had been in clinical practice at least 16 years and 84% of whom were in private practice) as to their experiences with religious and spiritual problems in psychotherapy. Humanistic-existentially oriented psychologists were the largest represented (25%) followed by "other" (22%), psychodynamic (15%), and cognitive (10%). She found 65% would use the V-code if finances or third-party reimbursement were not a prohibiting issue. Furthermore, 92% agreed that there was a qualitative difference between a psychotic episode and spiritual emergency or spiritual problem. In most cases, this had to do with level of daily functioning and reality testing. Although both of these studies provide preliminary evidence for the validity and utility of the V-code, additional empirical research is clearly needed.

Differential Diagnosis of Religious Problems from Psychopathology

Beyond additional empirical research, there is also a need for further conceptual clarification. Several authors have identified criteria for distinguishing between religious problems and pathology. For instance, Barnhouse (1986) indicated that when differentiating between psychotic disorders and other phenomena the content of religious language alone rarely determines its pathological significance. She recommended that an extensive religious history be included in every psychological evaluation.

Similarly, Greenberg and Witztum (1991) stressed that therapists must be thoroughly familiar with the basic tenets of a client's religion; otherwise, identifying pathology will be extremely difficult. Based on several decades of clinical experience with an ultra-orthodox Jewish sect in Israel, they proposed the following criteria for differentiating between normative, strictly religious beliefs and experiences from psychotic symptoms. Psychotic episodes (a) are more intense than normative religious experiences in their religious community, (b) are often terrifying, (c) are often preoccupying, (d) are associated with deterioration of social skills and personal hygiene, and (e) often involve special messages from religious figures.

Lovinger (1984) also offered guidelines for assessing religious problems to distinguish them from pathology. First, he suggested determining if the religious issue is "idiosyncratic or is rather an expression of group attitudes, ideas, or practices" (p. 177). For instance, speaking in tongues (glossolalia) should probably not be considered pathological for someone from a Pentecostal church community, but may be considered a problem for someone who is

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nonreligious. He concluded that clinical judgment and a thorough understanding of a client's background are required to make this type of distinction.

A concern with this criterion is that individuals may have atypical spiritual experiences for their particular cultural group and still these may not be evidence of psychopathology. For instance, it is generally not considered normal in mainstream U.S. culture to have directly heard the voice of God or to have witnessed spiritual beings. Yet many people who are not actively affiliated with any religious or spiritual movements that endorse these types of experience may still claim to have had similar unusual experiences (Bragdon, 1993; Grof & Grof, 1992; Hood et al., 1996). Though these experiences may differ significantly from one's cultural reference group, they do not necessarily signify psychopathology, a determination that often depends on the worldview of the clinician and his or her openness to nonpathological altered states of consciousness. It may also be contingent on other factors, including psychological history and amount of stress a person is currently experiencing. All of these complexities make distinguishing between religious experience and psychopathology challenging.

Second, Lovinger (1984) considered hallucinations and delusions with religious content as indicative of psychopathology, in contrast to transpersonal perspectives that might consider them *spiritual emergencies* (Bragdon, 1993; Grof & Grof, 1989). A spiritual emergency involves a psychological crisis as a result of unusual and/or intense spiritual or transpersonal experiences (Bragdon, 1993). In this regard, Lovinger (1984) failed to explain what he meant by hallucinations or delusions and seems to include all such phenomena as inherently psychopathological. However, Lovinger believed that hallucinations were similar in structure to dreams (i.e., consisting of complex imagery and symbols) and could be treated as such.

Third, Lovinger (1984) emphasized assessing the quality of the religious orientation. Although great strides have been made in shedding the pathologizing stigma championed by Freud (1907/ 1959) and Ellis (1980)[1] regarding R/S/T experiences, there may be harmful features in a client's religious beliefs and practices (Helminiak, 2001): for example, practicing one's religion in an overly scrupulous or fear-based manner. Humanistic psychotherapists should consider sensitively and mindfully identifying harmful beliefs and practices and addressing them in diagnosis and psychotherapy.

Two Proposed Diagnostic Systems

Based on many years of clinical experience, Lovinger (1996) updated his diagnostic criteria and delineated 10 markers of pathology (see Table 1).

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Table 1
Lovinger's (1996) Ten Markers of Pathology

1.	*Self-oriented display:* Narcissistic displays of being religious
2.	*Religion as reward:* Using religion to explain assistance with ordinary difficulties in life (e.g., God helping one find a parking space)
3.	*Scrupulosity:* Intense focus on avoiding sin or error
4.	*Relinquishing responsibility:* Feeling responsible for events beyond one's control and neglecting responsibility for manageable things
5.	*Ecstatic frenzy:* Intense, erratic emotional expression often containing religious content or occurring in religious contexts that may signal impending decompensation
6.	*Persistent church-shopping:* Suggests difficulties in maintaining stable relationships
7.	*Indiscriminate enthusiasm:* Religious enthusiasm frequently expressed to people who do not welcome it
8.	*Hurtful love in religious practice:* Expressions of love that unnecessarily cause harm to oneself or others (e.g., setting unrealistic expectations for a child out of a notion of love based on strict Biblical interpretations)
9.	*The Bible as moment-to-moment guide to life:* Applying scripture in concrete ways to direct one's daily experiences (much like a daily horoscope)
10.	*Possession:* May reflect underlying pathology such as hysteria, dissociative reactions, paranoia, psychosis, and borderline disorders

Lovinger's markers are insightful and interesting, but caution should be used in their application. According to Lovinger, clinicians should take a thorough religious and psychological history to determine whether patterns of pathology manifest themselves in other areas. That is, a person's ability to function at work, home, recreation, or in social settings should be considered. Questions to address at intake include whether a person's pathological religious expressions affect other psychosocial areas. If so, then psychopathology is deemed likely. Furthermore, informed clinical judgment is required to determine when the markers are, in fact, psychopathological and when they are acceptable religious expressions. As previously noted, the diagnostic process regarding R/S/T experiences is unavoidably subjective and influenced by the clinician's prior assumptions and world view. It remains enigmatic how clinicians can determine when phenomena such as Ecstatic Frenzy or a literal interpretation of the Bible as Guide are symptoms of pathology rather than a reflection of value differences between the clinician and client (see Table 1).

In one attempt to address this, Spero (1985) proposed eight diagnostic criteria for differentiating healthy from unhealthy religious expression (see Table 2). Spero intended these criteria to help determine when a person's

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Table 2
Spero's (1985) Criteria for Religious Pathology

1. Person integrates religious beliefs and practices into overall lifestyle (not pathological, but a necessary criterion).
2. Relatively rapid and recent onset of religious affiliation or increased religious fervor with associated severing of significant social and professional relationships.
3. Person's religious history includes frequent and repetitive spiritual crises and changes in religious affiliation or degree of belief.
4. Person demonstrates fixation or regression to early stages of object-relations development marked by decompensation in psychosocial functioning, predominant primitive thematic material in dreams, fantasy, and thinking, and conflict between religious expression and adaptive ego functioning.
5. Person preoccupied with fear of backsliding (consciously or unconsciously) and reaction formation of overly rigid and scrupulous religious expression.
6. Person displays continued depressed moods and lack of productivity following religious conversion or awakening.
7. Person inappropriately idealizes religious leaders or movement and applies this to resolving psychological issues such as autonomy, identity, and impulse control.
8. On occasion, an analyst's carefully interpreted countertransference may indicate the client is using religion to manage neurotic impulses.

religious beliefs or behaviors reflect underlying intrapsychic needs and conflicts rather than purely religious phenomena. Therefore, the utility of Spero's diagnostic scheme is limited to those who accept and understand psychodynamic language and theory.

Like most of the diagnostic suggestions reviewed, both Lovinger (1996) and Spero's (1985) systems lack empirical support. This has resulted in a serious lacuna in knowledge where research is sorely needed.

Differential Diagnosis of Spiritual Problems from Psychopathology

Grof and Grof (1992) argued that clinicians must "accept the fact that spirituality is a legitimate dimension of existence and that its awakening and development are desirable" (p. 252), although not always without complications. According to Lukoff and Turner (1996), "the clinician's initial assessment of powerful spiritual experiences can significantly influence the eventual outcome" of any intervention (p. 243). Inappropriate diagnoses by mental health professionals may intensify feelings of isolation and prevent understanding, assimilation of the experience, as well as future help

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seeking (Lukoff & Turner, 1996). However, it is also important that clinicians accurately diagnose psychopathology and not ignore or minimize problems that may have severe consequences. Even transpersonal psychotherapists agree that medication and hospitalization are required in some instances for severe decompensation (Grof & Grof, 1989; Lukoff, Lu, & Turner, 1998). However, differentiating R/S/T experiences from psychopathology can be extremely difficult because of similarities between pathological symptom expression and the unusual behaviors and perceptual characteristics found in these experiences (Lukoff et al., 1998; Lukoff & Turner, 1996).

Spiritual Emergency

Bragdon (1993) indicated three primary ways people respond to spiritual experiences: (a) gracefully integrate them into their lives and further develop spiritually and psychologically; (b) become temporarily overwhelmed and experience a spiritual and psychological crisis, but eventually accept the experience as part of their reality; or (c) fail to integrate the experience resulting in a chronic state of fragmentation. Bragdon argued that traditionally trained clinicians might diagnose all three responses as pscyhopathological based on the content of their experiences. For example, suppose a woman encountered a vision of light accompanied by a voice calling her to pursue a vocation in counseling. This calling may be integrated as a valid sign from God without decompensation in terms of social and emotional functioning. Nevertheless, if a mental health professional insensitive to experiences of this kind were consulted, she might be categorized as delusional or psychotic possibly leading to harmful consequences.

Distinguishing between R/S/T experiences and psychopathology requires a thorough understanding of what characterizes *spiritual emergence* and spiritual emergencies (Bragdon, 1993; Grof & Grof, 1992). Spiritual emergence refers to integrating spiritual or transpersonal experiences to achieve expanded consciousness and maturity whereas a spiritual emergency may result if R/S/T experiences result in psychological crisis.

Significant work has occurred in identifying spiritual emergencies that may technically meet the DSM-IV criteria for a psychotic episode but if approached differently might promote recovery and possibly integration to optimal levels of functioning (Bragdon, 1993; Cortright, 1997; Grof & Grof, 1992; Hendlin, 1985). First, clinicians should consider the intensity of the spiritual experience and level of functioning in daily life. Those whose daily functioning is significantly impaired by extremely intense R/S/T experiences

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are probably encountering a spiritual emergency. Second, people experiencing spiritual emergence usually display an attitude of excitement contrasted with the frightening and overwhelming stance found in a spiritual emergency. Finally, a clinician should consider how the person copes with society's reactions to their experience. In a spiritual emergency, the person might lack discrimination concerning who would be receptive to their experience and share their experience with people who are not interested or uncomfortable with it.

In recognition of the need to distinguish between spiritual emergencies that may lead to spiritual emergence if handled well or to psychopathology if handled poorly, the Spiritual Emergence Network (SEN) (see http://www.spiritualemergence.info/) was founded to create a national referral source providing mental health practitioners sympathetic to this perspective. SEN assumes that spiritual emergencies, as a specific type of spiritual problem, should be approached quite differently from psychopathology to avoid further decompensation or iatrogenic harm (Bragdon, 1993; Grof & Grof, 1989; Lukoff et al., 1998). For example, a person in a spiritual emergency might benefit from active social support, "grounding" (e.g., yoga or gardening) techniques, and spiritual guidance and/or psychotherapy rather than hospitalization and heavy medication (Grof & Grof, 1992).

Once it is determined that a person is experiencing a spiritual emergency, it becomes paramount to distinguish it from psychopathology. Grof and Grof (1992) recommended beginning with a complete medical evaluation to rule out contributing physical conditions. If the results are negative, they suggest diagnosing a spiritual emergency and treating it as such. If the psychological and spiritual interventions help, they continue with psychotherapy. If physical symptoms persist, however, they refer the client for a more thorough medical and psychiatric evaluation. If this evaluation excludes organic causes, then clinicians attempt to determine if the experience meets the criteria for a spiritual emergency or psychiatric disorder.

Many authors stress the importance of pre-episodic functioning (Bragdon, 1993; Cortright, 1997; Grof & Grof, 1992) in making this determination. If the history demonstrates generally healthy social, psychological, spiritual, and sexual functioning, then the person's current experience is viewed as psychospiritual and suggestive of a positive prognosis. In contrast, a history of dysfunction, as well as strong evidence of manic symptoms, poorly organized content within R/S/T experiences, self-destructive tendencies, and the presence of persecutory delusions or hallucinations may be indicative of psychopathology. In this case, traditional approaches to treatment such as medication and/or hospitalization may result in better outcomes (Grof & Grof, 1992).

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The DSM-IV simply does not differentiate psychotic hallucinations and delusions from religious and spiritual phenomena, such as visions and intense meditative experiences, and the DSM-IV does not discriminate between the disorganized and incoherent speech of the psychotic from the "noetic quality of spiritual experience" (Bragdon, 1993, p. 84). For example, the DSM-IV does not distinguish psychotic disorganized behavior from the unusual behaviors of a kundalini awakening. During a kundalini awakening, a person may sense intense feelings of heat pulsating up the spine, experience overwhelming waves of emotions, find it difficult to control behavior, and become extremely disoriented, all of which may appear as disorganized psychotic behavior. Bragdon (1993) admitted that distinguishing spiritual emergencies from psychopathology could be extremely difficult in people who are highly dissociative. She recommended clinical expertise and an open-minded stance that considers experiences of this kind as potentially representing spiritual emergencies rather than pathology.

Lukoff (1985) proposed several indicators for a positive prognosis following a spiritual emergency. The first indicator is good pre-episode functioning demonstrated by a healthy social network, intimacy with romantic partners, and an absence of prior psychotic episodes. The second is acute onset of symptoms occurred during a 3-month period or less. The third indicator included stressful precipitants to the psychotic episode such as trauma, divorce, loss of job, or death of a loved one. Finally, evidencing a positive exploratory attitude to the experience is often predictive of positive outcomes. Lukoff and Turner (1996) maintained that individuals who meet the criteria for a spiritual emergency should not be hospitalized and medication should be used minimally. They also recommended that helpers employ transpersonal approaches in treatment.

In one of the few empirical studies in this area, Hartter (1995) found that 92% of psychologists surveyed believed there was a difference between a psychotic episode and a spiritual emergency. In response to an open-ended survey question asking how they differentiate between the two, the psychologists identified the following eight criteria listed in descending order by prevalence: (a) Ability of client to function in reality or carry out daily life activities, (b) previous history of mental stability, (c) content of thought processes (conceptual organization or disorganization), (d) outcome that leads to wholeness or integration—is transformative, (e) content and organization of hallucinations and delusions, (f) neurochemical imbalances, (g) intact "religious belief system," and (h) duration of crisis. These findings closely resemble criteria found elsewhere in the literature (e.g., Bragdon, 1993; Grof & Grof, 1992; Lukoff, 1985). Given that these suggestions were

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given spontaneously in an open-ended format provides some validity to the criteria previously discussed.

Psychosis and Spiritual Experiences

In a rare study comparing spiritual experience and psychosis, Jackson (1991) compared five "undiagnosed" and five "diagnosed" participants, all of whom interpreted their experiences in spiritual terms. Members of the undiagnosed group met the following criteria: they reported an intense experience explained in religious or paranormal terms, the experiences were assessed as possibly involving delusions or hallucinations, apparent absence of functional deficits and evidence of positive social adjustment, and geographical proximity to the research center. Members of the diagnosed group were individuals who had recovered from major psychoses and interpreted their experiences in strongly spiritual terms.

Results indicated significant phenomenological similarities between the two groups. Each group manifested grandiose beliefs about their status, positive and negative emotional experiences, true and "pseudo" hallucinations, visual and auditory hallucinations, firm conviction in their "delusional" beliefs, and a lack of insight into the possibility that their experiences could be explained psychologically rather than spiritually. However, visual hallucinations were reported more often in the diagnosed group, as was the degree of symptom severity. For example, the diagnosed group reported being completely overwhelmed by their experiences, during which they lost contact with consensual reality and acted out their delusions in bizarre behavior, in contrast to less severe manifestations in the undiagnosed group. The diagnosed group also differed in that they unanimously indicated having had intensely negative experiences.

Subsequently, Jackson and Fulford (1997) investigated whether benign spiritual experiences could manifest psychotic phenomena. They also sought to explain the significance of this finding, if it occurred. They intensively interviewed nine participants from a database of more than 5,000 accounts of spiritual experience and strategically selected cases in which there appeared significant overlap between spiritual experience and psychotic illness. The semi-structured interviews covered the participants' background and history, the context, phenomenology, and effects of their spiritual experiences, and the interpretations that they and others placed on them. Traditional psychopathology defines mental illness by the form, content, duration, and intensity of symptoms and a lack of insight into their psychological origin (Jackson & Fulford, 1997). They found that the participants'

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spiritual experiences resembled the general form of psychotic phenomenon. For example, some of the participants demonstrated delusions and first-person auditory hallucinations. In terms of content, participants demonstrated benign symptomatology that differed from malign symptoms such as delusions of persecution. In addition, the participants described their experiences as intense and enduring. Overall, the phenomena were broadly defined as psychotic and likely to receive a diagnosis of psychoses in a traditional psychiatric setting. However, in many cases the experiences resulted in healthy and adaptive outcomes as interpreted by the participants and external observers.

Jackson and Fulford (1997) concluded that the mental health profession would benefit from reconceptualizing its notions of mental illness. They proposed a more balanced model that considers the evaluative nature of medical concepts and defines pathology as the patient's experience of incapacity (i.e., failures of ordinary intentional action). Jackson and Fulford emphasized that pathology should be understood as "essentially embedded within the framework of values and beliefs of the individuals concerned" (p. 53). They also argued that mental health professionals must recognize the value-laden nature of diagnosis and treatment.

In a comment on Jackson and Fulford's (1997) study, Littlewood (1997) stressed that mental illness and spirituality are always social or cultural phenomenon—neither are objectively "real." These concepts are " 'experienced through cultural meanings' not 'influenced by' culture" (p. 67). Storr (1997) criticized Jackson and Fulford's (1997) distinction between good and bad psychotic experiences. For Storr (1997), whether an experience is spiritual or pathological depends on the nature of the experience and the social setting. For instance, most everyone has had at least one psychotic episode (i.e., falling in love). Storr concluded his critique with the following thoughts:

> My own feeling is that the distinction "spiritual" versus "pathological" should be dropped. Everyone is liable to have deeply irrational experiences or hold deeply irrational beliefs that may be destructive or may be life-enhancing. Psychiatric diagnosis must include reference to the subject's personal relationships and his place in society as well as taking cognizance of his beliefs and mental experience as an isolated individual. Otherwise, we may condemn saints as psychotic, while treating serial killers as sane. (P. 84)

Thus, in all attempts at evaluating another human being's experience, the subjective, social, and cultural aspects of the evaluation process (including the evaluator and evaluated) should be considered.

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Assessment Approaches

Most psychological diagnosis focused on differentiating R/S/T experiences from psychopathology are based on using open-ended interview questions. Koenig and Pritchett (1998) suggested assessing religion and spirituality using four "non-offensive and easily remembered" (p. 327) questions. Likewise, Anandarajah and Hight (2001) presented a simple qualitative assessment approach, as have many others, but these are limited in usefulness. Some more sophisticated qualitative approaches to diagnose in this area have been proposed by Hodge (2000, 2001), such as family genograms, and may offer valuable data beyond using simple open-ended questions as part of humanistic psychological assessment of R/S/T problems.

In addition to these qualitative approaches, there is quite a robust psychometric tradition in the area of measuring R/S/T constructs. In one series of review articles on such measures, more than 100 were discussed (MacDonald, Friedman, & Kuentzel, 1999; MacDonald, Kuentzel, & Friedman, 1999; MacDonald, LeClair, Holland, Alter, & Friedman, 1995). However, little has been written on clinically using any of these measures for differential diagnoses and we could locate none that specifically provided norms or other essential information sufficient for responsible clinical applications.

One measure, however, has been explicitly discussed in terms of potential clinical utility, the Self-Expansiveness Level Form (SELF) (Friedman, 1983; Friedman & MacDonald, 1997, 2002). The SELF provides two subscales, a personal (P) and a transpersonal (T) measure of level of identification, which can be compared to each other to provide a sense of balance between a person's personal and transpersonal self-concept. Friedman (1983) theorized that a high T score without a correspondingly high P score could represent a psychopathological problem (i.e., a person who identifies more with the spiritual level than they do with the level of the lived experiences in the present). Friedman and MacDonald (1997) illustrated this with a vignette of one of his former patients, as follows:

> Millie is a commercial artist in her early 40s who also works as a minister in a New Age church where she does psychic readings. She scored very low on the Personal Scale of the SELF and very high on the Transpersonal Scale of the SELF. She sought psychological treatment after having a number of dissociative episodes that involved time loss and possible danger to herself, when she ended up in compromising situations. She sought a neurological examination but, after extensive medical workups, was referred for a psychological evaluation. The fact that she regularly dissociates when doing her psy-

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> chic readings in a controlled fashion was not seen by her as related to the episodes that she finds frightening. Her language is full of references to Spirit guiding her and she lives her life in accord with her visions and dreams. She gives short shrift, however, to her own personal needs and, in particular, has a difficult time conceptualizing that it is good for a person to find ways to meet their [sic] own personal needs; appropriate assertiveness, in particular, occurs rarely. She does get angry on occasion, however, including inappropriate violent outbursts with her boyfriend, but these make no sense to her, and embarrass her, in terms of her commitment to "Spirit" which she interprets as without anger. (P. 118)

In contrast, another one of Friedman's patients had both high T and P scores on the SELF but was not judged as psychopathological per se, though she had somewhat similar dissociative issues to Millie. Rather, she was diagnosed as undergoing a spiritual emergency, though she had previously been diagnosed by another clinician as having a dissociative identity disorder. Her concerns were expressed, however, in a quite different way from a usual psychopathology, particularly in terms of its adaptive function, as follows:

Jill, a member of a religious order, works as an administrator in a social services agency. She is in her late 40s, dresses very conservatively, and sought psychological treatment for work-related stress. She scored very high on both the personal and transpersonal scales of the SELF. There were many pressures on her at work regarding the dilemma between strictly adhering to legal rules and providing sorely needed benefits available to the poor and disabled served through her agency. She was frequently placed in the situation where she would either have to do something improper (e.g., regarding how a form might be filled out) or let a family literally go without food or shelter—and she had great difficulty reconciling this dilemma. At times like this, she found herself "disappearing," experienced as if someone else were doing the actions required. Though this was somewhat disturbing to her, her sense was that, during these very stressful times, it was an angel acting through her body. Her angel was viewed as a consummate administrator who could "cut corners" when needed to save lives, as well as could also deny services to those who might be needy but not in life-threatening circumstances. The angel enabled her to achieve a balance in her work that she could not personally manage. And her success as an administrator who could get things done despite the overwhelming need of her agency's clients and the bureaucratic constraints placed on her was widely admired. Nevertheless, she found the times when the angel was taking over

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to be somewhat disturbing, though she had implicit trust in the angel as an ego dystonic entity, and sought help for her "problem."

Contrasting these two cases, one previously published and one original to this article, is quite interesting insofar as both showed signs of a dissociative identity disorder but, in Millie's case, this placed her in danger whereas, in Jill's case, it was not only benign but also positively adaptive for her and those served by her agency.

What was apparently lacking in Jill, however, was the ability to see the angel as part of her own self, the one who could make the incredible difficult decisions with aplomb. Although Jill identified highly with both the personal and transpersonal aspects of herself as measured by the SELF, it was hypothesized that there was still room for her to grow in accepting her own personal limits, such as in being a member of a society that mandates ignoring the needy under certain legalistic circumstances, as well as in accepting that the angel really could be her own higher Self, notwithstanding the possibility of something supernatural and more in accord with her religious beliefs actually occurring here. In this sense, instead of psychopathologizing Jill's dissociativeness as a weakness, it was instead construed as a strength, but one that allowed for more growth, which became the focus of further psychotherapy.

The use of the SELF in differential diagnosis of R/S/T problems from psychopathology has not been empirically investigated, but offers one potential avenue for exploring this area. It is our contention that a wide range of methods should be explored to address this important differentiation, including qualitative interview and other qualitative methods, as well as psychometric approaches. What is most crucial is that this extremely important area not be ignored, as many people may be helped by further development in differential diagnosis in this area. And humanistic psychologists, being most open to the prevalent biases in mainstream misinterpretations of R/S/T experiences as only indicative of psychopathology should be in the forefront to develop these.

Discussion and Conclusions

This article has highlighted several attempts at establishing criteria for differential diagnosis of R/S/T experiences from psychopathology. Several conclusions and corresponding recommendations can be drawn. To begin, differential diagnosis requires openness, sensitivity, and knowledge about various forms of R/S/T experience. Clinicians and their clients will benefit

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from mental health professionals possessing more than cursory knowledge about common R/S/T experiences encountered in psychotherapy to aid in such diagnoses (e.g., Richards & Bergin, 2000). Given the subjective nature of diagnosis, diagnosticians and psychotherapists also require adequate self-awareness concerning their own beliefs and assumptions concerning R/S/T experiences. How these experiences are perceived will necessarily influence diagnostic practices, so mental health professionals should consider exploring potential sources of bias within their worldviews. Clinicians' openness to R/S/T experiences requires at the very least the ability to suspend judgment by bracketing biases for effective diagnosis and treatment to occur (Johnson et al., 2007; Morrow, Worthington, & McCullough, 1993).

In addition, it would be useful to develop sound empirical approaches, based on both qualitative and quantitative research, to aid in differential diagnosis in this area. The many research measures that have been developed demonstrate that this area is no less amenable to reliable and valid psychometric approaches than other areas of psychology. The next step for many extant measures would be to develop appropriate norms and explore other psychometric properties necessary for the responsible clinical application of these instruments, as well as the development of new measures specifically useful for the differential diagnosis of R/S/T experiences from psychopathology.

Furthermore, mental health professionals might familiarize themselves with the diagnostic systems presented in this article, especially as summarized in the article's tables. From these systems, we can conclude several recommendations for "best practice" (see Table 3). For example, taking a thorough R/S/T history as part of a holistic biopsychosocial history is a necessity when determining whether unusual R/S/T experience may or may not be psychopathological. Evidence of previous episodes of psychosis, dysfunctional relationships, or religious crises may be crucial in such a differential diagnosis. Also, knowing relevant markers of psychopathology (e.g., scrupulosity) found in religious expression may help determine whether a client's religious orientation is life enhancing or detracting. As a profession, we should consider courageously and mindfully examining what benefits whom and when.

Moreover, Lukoff et al. (1992, 1996) provide helpful criteria for determining more precisely the nature of religious and/or spiritual problems and resulting treatment strategies. Is the problem purely a theological issue? Then perhaps appropriate clergy should be consulted. Are there concurrent mental or physical disorders that require attention or is the primary issue distress of a spiritual nature sans mental or physical disorder? Increased precision in diagnosis may increase sensitivity to clients and improve treatment

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Table 3
Recommendations for Differential Diagnosis of Religious/Spiritual/Transpersonal (R/S/T) Experiences from Psychopathology

1. Accept reality of spiritual and transpersonal experiences.
2. Obtain thorough understanding of clients' religious history and background.
3. Realize that psychopathology cannot be determined solely by content in clients' R/S/T experiences.
4. Assess adaptive functioning preceding and following R/S/T experience, whether symptoms are acute or chronic, and level of openness to exploring spiritual experiences.
5. Assess quality of clients' R/S/T orientation.
   a. Does current behaviors/practices exceed religious injunctions?
   b. Does client overemphasize certain practices or beliefs and neglect others?
   c. Do beliefs and practices promote wholeness, relatedness and full humanness?
6. Compare idiosyncratic behavior and beliefs to normative practices in religious/ spiritual community (e.g., speaking in tongues, hearing the voice of God).
7. Determine nature of religious or spiritual problem (Lukoff et al., 1992, 1996).
   a. Purely religious or spiritual problem.
   b. Mental disorder with religious or spiritual content.
   c. Religious or spiritual problem concurrent with mental disorder.
   d. Religious or spiritual problem not attributable to mental disorder.
8. Recognize and understand spiritual emergency versus spiritual emergence (Grof & Grof, 1992).
9. Recognize that psychopathology is often characterized by greater intensity, terror, and decompensation than genuine spiritual experience.
10. Consider markers of religious psychopathology (Table 1).
11. Consider intrapsychic conflicts manifested as religious pathology (Table 2).
12. Consider assessment tools for identifying adaptive from maladaptive spirituality (e.g., the SELF).

outcomes. Finally, familiarity with spiritual emergence and emergency and how they differ from psychopathology may prevent misdiagnosis and subsequent iatrogenic harm. People in spiritual emergencies in particular may greatly benefit from contextualizing their experiences in transpersonal terms and treatment that includes grounding techniques and use of a spiritual community, as opposed to psychiatric medication and hospitalization.

Note

1. Ellis (2000) later recanted his rejection of religious/spiritual/ transpersonal experiences as inherently psychopathological and has recently even seen some value in exploring, rather than merely debunking, these in psychotherapy.

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