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Mysticism and madness: different aspects of the same human experience?

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INTRODUCTION

Many people, through various routes, have experienced what have become known as altered states of consciousness (ASCs). By “altered” what is meant is that the way experience is both taken in and framed is different from one’s ordinary day-to-day experience. The two main routes of alteration (perhaps each as old as humanity) are through substances (chemicals in plants or synthetics) and practices that loosen up the way the mind structures experience. Altered states can also occur through near-death experiences, great stress, or spontaneously without any obvious cause.

One of the most life-changing of these altered states is the *mystical experience*: a transitory state of consciousness in which an individual purports to come into immediate contact with the ultimate reality. It involves the awareness of an abstract, non-physical power which is far greater than the individual self. When occurring, this experience is considerably different from any other as it induces the sense of another (probably higher) dimension to life; that the everyday world is not the whole reality. Although they are usually infrequent and rather fleeting, such experiences often stand out as defining moments in the lives of those who have them.

The term *mysticism* can be seen as referring to conscious and systematic attempts to gain mystical experiences through studies and practice (e.g. meditation, asceticism, prayer, chanting etc), although it may be that religious mystics encounter mystical experiences as by-products (rather than goals) of their religious life. In its own right, however, mysticism is religiously and philosophically neutral, and the interpretation and expression of these experiences will depend upon the background of the person involved and the context in which the mystical endeavour was undertaken. Because mysticism is typically undertaken in the context of a strong religious motivation, it is usually associated with religion. But it need not be; and it is feasible to be a materialist and an atheist and still be a mystic. As William James points out, mystical experiences may happen to anyone, regardless of religious training or inclinations (James, 1901/02).

Over the years, mystical experience has been the focus of much attention mainly due to its pivotal role in the study of religion. Indeed, the very meaning of many religious

symbols, scriptures, practices, and institutions is believed to lie in the experiences they elicit in people's minds. Mystical experience is also thought to constitute the very essence of religion, such that the origin of a given tradition can often be traced to an initial transcendent encounter, moment of revelation, salvation, or enlightenment (i.e. the direct experiences of Buddha, Muhammad and Paul clearly played a major role in the formation of their respective religions). Additionally, there are many who feel that the only way to truly appreciate and understand the divine is by first hand experience; i.e. by partaking in ultimate reality oneself.

The slightly unusual nature of mystical experience can readily lead an observer to conclude that it is a sign of mental disturbance. In fact, mystical experience and madness have been associated since the earliest recorded history. Socrates declared that 'our greatest blessings come to us by way of madness, provided the madness is given us by divine gift' (cited in Dodds, 1951). In the days before scientific theories of mental illness, madness was typically attributed to supernatural or divine causes. Insanity was explained either as being inflicted by the gods as punishment for wrongdoing (e.g. Moses proclaims: 'The Lord will smite thee with madness' (Deuteronomy 28: 28)), or as another entity taking over an individual's body (demonic possession). In the early Middle Ages, exorcism was the preferred treatment for madness, however, when it was discovered that people (mainly women) could voluntarily invite the Devil into their bodies, the obvious 'cure' was then to eliminate the host. The 15th century witch-hunting manual, *Malleus Maleficarum* details how the Devil and his followers, witches, perpetrate a variety of evils with 'the permission of the Almighty God' (Kramer & Sprenger, 1486). It was not until the turn of the 18th century that religious explanations for madness started to be replaced by the more scientific explanations that we hold today.

The age-old association between religion and madness has helped to fuel several, more recent explorations of the relationship between mystical and psychotic experience. (The term 'psychotic experience' is used here to refer to the experience of 'positive symptoms' – hallucinations, delusions and other reality distortions, which could be, or have been, taken as evidence of a psychotic disorder, on the basis of contemporary psychiatric definitions.) From these explorations, it has been widely noticed that psychotic experience shares some important areas of correspondence with

mystical experience (e.g. James, 1901/02; Boisen, 1960; Laing, 1967; Jackson & Fulford, 1997). Perhaps most famously, William James observed that: ‘Religious mysticism is only one half of mysticism. The other half has no accumulated traditions except which the text-books on insanity supply. Open any one of these, and you will find abundant cases in which ‘mystical ideas’ are cited as characteristic symptoms of enfeebled or deluded states of mind’ (James, 1901/02). The idea that mystical and psychotic experience might actually define the same range of phenomena has led various commentators (mainly advocates of the ‘medical’ model of mental illness) to conclude that mystical experience must therefore be pathological. One prominent figure among this group is Sigmund Freud (Freud, 1927; 1930).

When Freud proposed his ‘universal neurosis’ theory of religion (Freud, 1927), he was confronted with firm opposition claiming he had not fully appreciated the true source of mystical experience. In *Civilisation and its Discontents* (1930), Freud mentions a letter he received from Romain Rolland, describing mystical experience: ‘a feeling which he would like to call a sensation of “eternity”, a feeling of something limitless, unbounded as it were, “oceanic” ... One may, he thinks, rightly call oneself religious on the ground of this oceanic feeling alone’. While Freud is comfortable with the existence of such a feeling, he suspects that it was originally unconnected to the religious phenomena. Instead, he reduces the experience to being no more than a temporary psychosis arising from the persistence of undifferentiated-ego feelings from infancy.

A similar view to Freud’s is evident in a report by the Group for Advancement in Psychiatry, who define the mystical experience as ‘borderline psychosis ... a regression, an escape, a projection upon the world of a primitive infantile state’ (GAP, 1976). The authors also state that upon ‘reading the recorded descriptions of mystical states, we might well be inclined to make a diagnosis of some serious mental illness, most frequently hysteria or schizophrenia; occasionally manic-depressive illness’ (GAP, 1976). Other commentators on this subject have also regarded mystical experience as being symptomatic of a psychotic episode (Horton, 1974), or temporal lobe dysfunction (Mandel, 1980).

This essay will firstly explore the kinds of similarities between mystical and psychotic experiences which have prompted the emergence of such theories. By then proposing a common element to both mystical and psychotic experience (referred to here as the experience of ‘oneness’), we will endeavour to place mysticism and madness onto the same experiential continuum. However, in contrast to much of the previous literature (outlined above), the intention will not be to ‘pathologise’ mystical experience, but rather to ‘normalise’ psychotic experience. The paper will not only argue that the experience of ‘oneness’ is entirely genuine and available to all humans, but also that it has an important psychological (and evolutionary) function. Using cognitive terminology, we will then attempt to explain the processes determining whether an individual enjoys a fulfilling mystical experience, or suffers a devastating psychotic breakdown (i.e. *how* ‘oneness’ is experienced). Finally, this paper will turn to look at some of the important implications such an approach might have for clinical practice and for the mental health of people in general.

SIMILARITIES AND DISTINCTIONS

Mystical and psychotic experiences are both ‘altered states of consciousness’, occupying the space where reason breaks down, and mystery takes over. The most striking resemblance between the two experiences is in their content. Clinical observations have shown that preoccupation with religion is a common characteristic of psychotic thinking (as it is of mystical thinking). Voices that people hear are frequently attributed to God, the Devil, or other supernatural entities. Delusions, particularly grandiose delusions of identity, often involve religious figures, and the characteristic psychotic discourse is suffused with the supernatural, or a sense of spiritual importance (Clarke, 2000). In both mystical and psychotic experience there is a prevailing sense of being guided by an external power, a perception of meaning in events, and a special purpose / mission in life. These phenomenological parallels are typically accompanied by an adamant conviction, which is conveyed in both kinds of experience (Jackson, 2001).

As well as this clear overlap in content, there is also evidence for there being similar emotions involved at the onset of experience. From clinical practice, Clarke (2001) observes that, as with mystical experience, there is an initial stage of euphoria that is

common in early psychotic breakdown. She suggests that ‘the most obvious difference between this euphoria and that encountered in the more exuberant forms of spiritual experience, is the disaster that characteristically follows, and which constitutes the generally recognised psychotic experience’ (Clarke, 2001). Other commentators have noted a wide variety of phenomena, such as time distortion, synesthesias, hallucinations (auditory and visual), loss of self-object boundaries, social withdrawal, and the transition from a state of conflict and anxiety to one of sudden “understanding”, all of which are reported in both mystical and psychotic experiences (Buckley, 1981; Jackson & Fulford, 1997).

In one interesting study, Mike Jackson compared a subset of the normal population who reported mystical experiences (“undiagnosed group”) with individuals who had recovered from major psychoses but nonetheless interpreted their experiences in strongly spiritual terms (“diagnosed group”) (Jackson, 1991; 2001). The study sample was selected from the archives of the Religious Experience Research Centre (RERC), which was initially set up by Sir Alister Hardy in 1969. (The RERC, now situated at the University of Wales, holds over 6000 accounts of first-hand mystical experiences that have been collected via advertisements in newspapers etc.) Jackson reports that ‘the experiences described in both groups involved broadly similar phenomena, but these tended to be more negative and overwhelming in the diagnosed subjects’ (Jackson & Fulford, 1997).

The differences in *emotional tone* of experience noticed by Jackson had previously been picked up on by James, who argued that in ‘delusional insanity’, as opposed to mystical experience, ‘the emotion is pessimistic: instead of consolations we have desolations; the meanings are dreadful; and the powers are enemies to life’ (James, 1901/02). So, while there may be a common initial euphoria to these experiences, the overriding emotions seem to be generally more negative in psychotic experience. As Jackson states, ‘Experiences of both hedonic extremes were reported in both groups then, although negative extremes were more common in the diagnosed group’ (Jackson, 2001).

Other attempts to distinguish between these two phenomenologically similar experiences have focussed around the element of *control*. The main point here is that

mystical experiences are generally sought after (as mentioned in the opening remarks on mysticism), and typically involve a controlled entry into and out of these states. In psychosis, however, the experiences are largely unwanted, and tend to be out of the individual's control. In an intriguing account of his own psychotic breakdown, Peter Chadwick touches on these two distinguishing factors of *emotion* and *control*: 'unlike a Zen meditator who may have similar experiences in a state of tranquillity and low arousal I had accessed this domain in great agitation' (Chadwick, 1992).

Further distinctions have been drawn between the behavioural consequences of mystical and psychotic experiences. Where mystical experiences usually have adaptive and life-enhancing consequences, similar phenomena in psychosis often lead to social and behavioural impoverishment (Peters, 2001). In a detailed comparison of mysticism and psychosis, Greenberg and colleagues concluded that hallucinations, and grandiose and paranoid delusions did not distinguish the psychotic from the mystic, and a diagnosis of psychosis rested on associated factors such as the duration of the state, ability to control entry into the state, and deterioration of habits (Greenberg *et al*, 1992). However, we must be cautious when considering behavioural consequences, because they are typically associated with the *negative* symptoms of psychosis (e.g. apathy, withdrawal, flat or blunted affect, inactivity etc.), and as stated above, we are more concerned with 'psychotic experience' as being the experience of acute *positive* symptoms. Furthermore, many negative symptoms of psychosis may be understood (from a cognitive perspective) as simply being 'safety behaviours' to avoid exacerbations in the positive symptoms (Morrison, 2004).

If, as the evidence suggests, there is no clear distinction between the content and type of phenomena experienced (but only in *how* they are experienced), the next step is to break the experiences down in search for a *common element*. We will return to the issue of *how* mystical and psychotic states are experienced in the section headed, '*The Appraisal of Oneness*'.

A COMMON ELEMENT?

The concept of 'breaking down' reported experiences to find common, or 'core' elements is certainly not new to the literature on mystical experience (e.g. James,

1901/02; Huxley, 1944; Stace, 1960; Hood, 1975). However, due to the powerful dominance of the ‘medical’ (biological) model of mental illness, there has been relatively little attention paid to the actual content of psychotic experience in the psychosis literature. Most psychiatric researchers have accepted that delusions are ‘empty speech acts, whose informational content refers to neither world or self’ (Berrios, 1996). As a result, in the discussion that follows, most sources will be drawn from the ‘mystical experience’ literature and then incorporated into models of psychosis, based on the noted similarities between the two experiences.

The most basic question faced by those who have been involved with the study of mystical experience is whether the experiences people have are the same or different from each other. Many have claimed that the *core* experience itself is not affected by linguistic, cultural, or historical contingencies. This ‘common core’ or ‘perennialist’ thesis (as advanced by James and Huxley) holds that the essence of all mystical experiences is the same, and that their different descriptions are due to the particular interpretations imposed on them through the various traditions. Walter Stace, another firm advocate of the perennialist position, put forward a set of universal core characteristics derived from his studies of Christian, Islamic, Judaic, Buddhist and Taoist mystical sources (Stace, 1960). Of the seven characteristics Stace identified, the first stands out as the ‘very essence of all mystical experience’: the disappearance of all physical and mental objects of ordinary consciousness and, in their place, the emergence of a unitary, undifferentiated, or pure consciousness.

In the past few decades, however, these perennialist approaches to mystical experience have come under concerted attack from a number of scholars, notably Steven Katz (1983) and Wayne Proudfoot (1985). The critics note that we do not have access to mystical experiences *per se*, and that the very notion of separating an ‘unmediated’ experience from a culturally determined description is philosophically suspect. Such views have led to the emergence of a ‘constructivist’ thesis, which claims that all experience is mediated by language or learning of some kind. No pure experience exists that is not constructed by the language or concepts which enable it, and through which it is seen (Proudfoot, 1985). The extreme constructivist position therefore holds that mystical experience is *wholly* shaped by a mystic’s cultural

environment, personal history, doctrinal commitments, religious training, expectations, aspiration, and so on.

This brief overview of the two main philosophical positions shows us how the perennialist – constructivist debate has tended to go to extremes, with some claiming that mystical experience is completely unmediated, and some claiming that it is just as mediated as any other experience. However, as Watts points out, another reasonable (and often overlooked) possibility is that mystical experience is ‘less constrained by background cultural and cognitive processes than most experience, though not absolutely free of such influences’ (Watts, 2002). In its attempt to avoid the central (polarised) debate, this middle position instead begs the questions of *how much* influence contextual factors have on mystical experience, and what *other* factors are involved? Robert Forman would argue that this kind of ‘partial constructivism’ is not enough to discard the common core perennialist thesis anyway. He says that unless the constructivist believes every single aspect of mystical experience to be mediated, then there is always the possibility of a common core lying in the unmediated aspect (Forman, 1990).

As there appears to be no obvious conclusion to this philosophical debate, one is forced into making assumptions for individual purposes. Because, in this essay, we are interested in the overlap of mystical experience with psychotic experience, we will adopt the perennialist assumption that there is a *central essence* which accounts for the similar content of these experiences, while their different descriptions are due to individual contexts and appraisals. So what exactly is this core experience? Again, we will primarily turn to the literature on mystical experience to pursue this question.

THE EXPERIENCE OF ONENESS

Ralph Hood (1975) proposes that all mystical experiences can be placed into either one of two major categories: the transcendent experience and the immanent experience. The transcendent experience involves the sense of being in contact with the divine and/or creative energies outside oneself, whereas the immanent experience involves the sense of the divine presence pervading and unifying all things. Hay & Heald (1987) showed that experiences of transcendence are more commonly reported

in Western cultures (with monotheistic conceptions of the divine), and experiences of immanence are prevalent in the Eastern cultures (with pantheistic conceptions). Moreover, Smart (1996) identified the presence of both kinds of experience amongst those who had encountered transcendence, but one of pure immanence for those with no previous cultural concept of the ‘Other’. It is argued that the experience of transcendence arises from a human tendency to personalise the ultimate reality, and so if we are to discern a ‘core’ experience, a common factor exempt from both cultural and individual influences, it would appear to be that of immanence: i.e. experiencing an underlying unity within all existence. We call this the experience of *oneness*.

‘Therefore it is in Oneness that God is found and they who would find God must themselves become One ... And truly, if you are properly One, then you shall remain One in the midst of distinction, and the multifold will be One for you and shall not be able to impeded you in any way’. (Meister Eckhart – the great Christian mystic, translated in Davies 1994)

Although this working assumption deliberately avoids arguments for a core theistic / transcendent experience, we will learn how the notion of oneness not only draws together the mystical experiences of different religious traditions (East and West), but also allows us to bring psychotic experience into the same experiential domain. Previous commentators on the similarities between mysticism and madness have often struggled to find a single, comprehensible term to refer to the shared area of experience (Clarke, 2001). Terms such as ‘transliminal’ (Thalbourne *et al*, 1997; Claridge, 2001) and ‘p-s experience’ (Jackson, 1991) have been designed to capture the broad experiential state, while simultaneously avoiding either psychotic (pathological) or mystical (spiritual / supernatural) connotations. The term ‘oneness’, which will be used in this paper, is not only able to fulfil a similarly ‘neutral’ role, but is also useful for understanding both the *function* and *appraisal* of this universal area of experience (as we discover in later sections).

The experience of oneness and its associated processes can be conceptualised using either neurological or cognitive terminology. By briefly exploring both theoretical accounts in turn, we will hopefully begin to understand why this experience of oneness might reasonably be placed at the very core of all mystical and psychotic

experience. As we will see, each account is strongly centred on the pervading sense of ‘ego-loss’; a prominent feature in reports of both mystical and psychotic experience.

A Neurological Account

d’Aquili and Newberg have developed an impressively detailed account of mystical experience based upon their own research into the brains of Tibetan Buddhist monks and Catholic nuns during meditation and prayer (d’Aquili & Newberg, 1999; Newberg *et al*, 2001). They begin by describing how we all frequently slip into mild unitary states when our brain’s orientation area is deafferented (i.e. deprived of neural input). This might happen when we engage in ritualistic or rhythmic behaviours, when we listen to music, or even when we relax in the bath. They say that the intensity of the unitary state is determined by the degree to which the orientation area is deafferented, and that it is not until deafferentation is at its most advanced that we might experience states of spiritual union.

The authors go on to describe how mystics can train themselves to focus the meditative powers of their mind to carry them to these deeper states of union with the divine. They claim that all the various forms of meditative practice adopted in all parts of the world share a common goal: ‘to annihilate the ego’, or ‘to quiet the conscious mind and free the spirit from the limiting passions and delusions of the ego’ (Newberg *et al*, 2001). Essentially, the meditator’s continued intention to clear his or her mind of thoughts can eventually lead to the complete deafferentation of the orientation area. They suggest that in this state, the mind would no longer be able to find the boundaries of the body, thereby making its perception of self become limitless. In fact, they say that there would be no subjective self at all; only an absolute sense of unity – without thought, without words, and without sensation. Their name for this state is ‘Absolute Unitary Being’ (Newberg *et al*, 2001).

One of the great appeals to d’Aquili & Newberg’s theory is that it acknowledges the subjective dimension to mystical experience (i.e. sensations of unity and oneness) while still remaining within the boundaries of empirical science. Their model also seems to be able to account for the ego-breakdown (caused by sensory manipulation), which precipitates the experience in the first place. However, what this neurological account is not able to do is offer any clues about the *function* of this experience, or

why it is held with such great, and often life-altering, importance. The significance of this latter aspect becomes obvious when you consider the many millions of people across the world (mainly from Eastern traditions), who regard mystical experience as the very meaning and goal of life itself. So, despite its scientific credibility, d'Aquili & Newberg's neurological model still lacks a certain amount of explanatory power.

A Cognitive Account

In an early cognitive account, Batson & Ventis (1982) analogise the mystical experience with another reality-transforming experience, namely the creative experience. They refer to the classic work of Graham Wallas (1926), who identified a four-stage sequence in the creative process: (i) *preparation* (the asking of important questions), (ii) *incubation* (abandoning these questions), (iii) *illumination* (new insight occurs), and (iv) *verification* (solution is tested and implemented). With the belief that creative and mystical experiences differ only in content, rather than process, Batson & Ventis propose their four-stage model of mystical experience: (i) *existential crisis* (personal existential questioning), (ii) *self-surrender* (despair at failing to discover existential meaning), (iii) *new vision* (transcending old cognitive structures to reveal new meaning), and (iv) *new life* (living the vision with new cognitive structures). The *new vision* stage represents that which is typically considered to be the mystical experience, and is equivalent to Wallas's *illumination* stage in the creative process.

In a later book, '*Religion and the Individual*', Batson and colleagues support this cognitive model by considering the actions of mystical experience *facilitators*, most notably drugs and meditation (Batson *et al*, 1993). Throughout history, people have been known to use various substances and techniques for spiritual purposes, and in the 1960s, psychedelic drugs even became a major tool in the empirical research of mystical experience (Pahnke, 1963; Leary, 1964; Clark, 1969). With regard to meditation, Batson *et al* make a similar point to Newberg *et al* (2001), claiming that it 'stops the flow of thought and brings the mind to one-pointedness' (Batson *et al*, 1993). Other practices that have been identified as mystical experience facilitators such as fasting, sleep deprivation, breathing techniques, chanting etc also seem to act directly upon the senses, and cause the ego to weaken.

Batson *et al* argue that the sensory distortion and manipulation caused by facilitators would encourage the *incubation* stage in their model because ‘the grip of present reality is loosened’ and ‘attempts to solve problems using old cognitive structures become more difficult’. They also suggest that psychedelic drugs may have an additional impact on the *illumination* stage because the mind comes ‘alive with new combinations of sensations, ideas, and memories’ that create ‘the potential for seeing oneself and one’s world differently’ (Batson *et al*, 1993).

Unlike the neurological model of d’Aquili & Newberg, this cognitive account is able to provide an explanation for the life-changing qualities of mystical experience (new cognitive structures), as well as an understanding of the self-loss or ego-breakdown that occurs (letting go of old cognitive structures). Because these qualities are also notable features of the psychotic experience, this cognitive conceptualisation appears to be highly supportive of the essay’s central argument. Furthermore, recreational drug abuse has long been recognised as a precipitating factor in psychotic illness (Verdoux *et al*, 2005).

The original ideas of Batson & Ventis have led to further explorations by other cognitive theorists (Jackson, 2001; Clarke, 2001). Isabel Clarke outlines a model to describe the ‘transliminal’ state by drawing upon George Kelly’s (1955) personal construct psychology (PCP), which regards the individual as possessing numerous constructs (or predictions) that constitute their unique model of the world. While these constructs are formed of previous experience, they are flexible, and can be loosened (or expanded) to accommodate novel situations. Once loosened, it is important that the constructs then consolidate the new material by re-tightening, so that valid future predictions can continue to be made. Clarke suggests that in certain situations where predictions are not needed, or where current constructs are totally inadequate, the construct system might be loosened to such a degree that it is temporarily suspended. It is this suspension of, or ‘moving beyond the construct system’ that creates a ‘transliminal’ state, where mystical and psychotic experiences become possible (Clarke, 2001). (We have already touched upon the philosophical issues surrounding the idea of unconstrued / unmediated experience.)

There are some similarities between Clarke's model and the model of Batson & Ventis, but where Batson & Ventis place mystical experience in the formation of a new construct system (or cognitive structure) that transcends the old, Clarke places mystical experience in the absence of any construct system. I believe that both conceptions are necessary for a complete picture. Where Batson & Ventis's model can explain the psychological causes and determinative effects of mystical experience, Clarke's model can explain its principal qualities (such as 'oneness' sensations and ineffability) as being the result of conceptual boundary-loss. So, by combining the two, we would have a fairly comprehensive cognitive model that involves three main steps: (i) *construct system breakdown*; (ii) *temporary suspension of constructs*; and (iii) *construct restructuring*. Steps (i) and (ii) of this simplified cognitive model correspond to d'Aquili and Newberg's neurological account of (i) deafferentation / ego-breakdown, resulting in (ii) an unbounded, unitary state (or what we have termed the experience of oneness).

THE FUNCTION OF ONENESS

Having placed the experience of oneness at the heart of a three-step cognitive process, we are now in a position to investigate its possible function (or more accurately, the function of the process in which oneness plays a central role). To suggest that the oneness experience has a psychological function is not to deny that it may also have a spiritual / religious function (it may be that God reveals himself to man by way of the same psychological process). However, what it does challenge is the dominant 'medical' model that such experiences are symptomatic of biological illness (or mental 'abnormality'). To say that psychotic (and mystical) experiences may have a genuine human function flies in the face of the established psychiatric viewpoint that 'schizophrenia is a chronic, severe, and disabling brain disease' (US National Institute for Mental Health, cited in Read *et al*, 2004).

We will start exploring the function of oneness by referring back to the original Batson & Ventis analogy between mystical and creative experience. As we know, Batson & Ventis describe the creative experience as part of a problem-solving process, triggered by high levels of cognitive tension (which it then reduces through cognitive restructuring). They suggest that mystical experience involves the same

underlying process as the creative experience, but that the precipitating crises are existential rather than intellectual (involving emotional as much as cognitive ‘tension’), and that ‘solutions’ involve metaphysical rather than theoretical paradigm shifts (Jackson, 2001). Essentially, mystical experience is regarded as part of an *existential problem-solving process*, and therefore has a genuine *adaptive* function.

If we are to now apply this same model to psychosis, we must presume that the psychotic experience is also some kind of ‘solution’ (i.e. an event, or insight that is potentially ‘useful’ for the individual, in that it acts to resolve a psychological crisis). At first glance, it would seem that psychotic experience is anything but ‘useful’, judging by the intense suffering which follows. Moreover, Jaspers concluded that the contents of psychotic experience were completely ‘un-understandable’ in the context of an individual’s psychosocial background, and it was more likely that these experiences emerged as the surface manifestations of some kind of biological dysfunction (Jaspers, 1913). However, recent observations and studies have shown that the content of many delusions and hallucinations are, in fact, understandable and person-specific, in that they are shaped by the individual’s psychological and emotional makeup. Fowler *et al* state that: ‘In many cases psychological rather than biological processes may be of primary importance in shaping the experience of psychosis’ (Fowler *et al*, 1995).

The recognition that psychotic content is *relevant* to the individual lends some support to the cognitive problem-solving model, but the most crucial question is whether or not this content is actually *adaptive* (i.e. does it solve a problem for the individual?). In Jackson’s study of diagnosed and undiagnosed subjects, he noticed that the mystical experiences of the undiagnosed group were ‘positively life-enhancing, in that they involved pragmatically useful ‘solutions’ to threatening personal crises’ (Jackson, 2001). Although in the diagnosed group, life-functioning was seriously impaired by the experiences, subjects felt that they had still somehow ‘answered their psychological needs at the time’. Jackson reports that ‘such experiences were potentially emotionally resolving: however, they had more negative ramifications’ (Jackson, 2001).

These observations look promising for a problem-solving model, but because the biological model of psychosis has generally entailed the neglect of patients' understandings of their own experience (Geekie, 2004), studies of this nature are few and far between. This is reflected in the conclusion of a review article in the *British Journal of Clinical Psychology*: 'research dealing with patients' own attributions for their illness has been virtually non-existent' (Molvaer *et al*, 1992). As a result, we are still unsure about how readily Jackson's findings can be replicated.

Some recent research by Geekie (2004) has shown that psychotic patients often implicate 'internal psychological processes' in the genesis of their psychosis. He identifies a number of specific emotional explanations (such as 'guilt' and 'uncertainty'), as well as the more general notion of 'overwhelming emotional arousal'. There were also explanations related to aspects of their self (such as 'introspection' and 'conflict with self'), and information processing (such as 'cognitive overactivity' and the 'questioning of fundamental beliefs'). Geekie highlights the 'questioning of beliefs' as a perceived causal factor, quoting patient A:

'I questioned too many things all at once and without having an answer drew assumptions. It was just like cutting out my own foundation, and I didn't have much to stand on in the end, so I made myself vulnerable' ('A', Geekie 2004)

We can relate patient A's account to the first three steps of the Batson & Ventis (1982) problem-solving process: (i) *existential crisis* ('I questioned too many things'), (ii) *self-surrender* ('without having an answer'), (iii) *new vision* ('drew assumptions'). Even though the outcome of this process was highly detrimental to patient A ('I made myself vulnerable'), it can still be seen as *adaptive*, because the 'assumptions' temporarily 'solved' the problem of not having an answer. This demonstrates how an adaptive psychological process might not necessarily be beneficial for the individual in the longer term (as is clearly the case in psychosis). (We consider the factors determining the outcome of this process in the next section). The argument that psychotic experiences may be adaptive 'solutions' to existential crises, rather than pathological 'manifestations' of brain disease, is further supported by the clinical observation that patients' delusional beliefs are nearly always about their position in the social universe (Bentall, 1994) or core existential concerns (Musalek *et al*, 1989).

If mystical and psychotic experiences can be explained in terms of the same underlying problem-solving process (which involves a ‘core’ experience of oneness), then this process, and this experience, must be *universal*, and not just available to mystics and psychotics. Thus, we should expect to find evidence of mystical and psychotic experiences in the general population.

There have been a number of surveys carried out to explore the prevalence of mystical experience in Western populations. In the US, more than 40% of individuals claim to have had experiences that they define as mystical (Greeley, 1987), and of 1865 people surveyed in the UK, 35% answered “yes” when asked, “Have you ever been aware of or influenced by a presence or a power, whether you call it God or not, which is different from your everyday self?”. The percentage was higher among the more educated, where as many as 56% answered “yes” (Hardy, 1979). The prevalence of these experiences is likely to be even greater in Eastern populations, where mysticism is not only recognised as the very quintessence of religious consciousness, but also as the ultimate goal of man’s spiritual aspiration. Clearly, mystical experiences do affect a sizeable (if sometimes silent) proportion of the population.

Similarly, in the psychosis literature, there has been a recent surge of interest in the incidence of psychotic experiences and beliefs in the general population (Tien, 1991; Verdoux *et al*, 1998; Day & Peters, 1999; van Os *et al*, 2000; Poulton *et al*, 2000; Brett, 2004). Although only 1-3% of the general population experience a diagnosed psychotic episode at some point in their lives (APA, 1994), large-scale population studies have shown that 10-15% have had some kind of hallucinatory experience (Tien, 1991; Poulton *et al*, 2000), and up to 70% endorse beliefs that could be labelled as delusional (Verdoux *et al*, 1998). The Netherlands Mental Health Survey and Incidence Study (NEMESIS; van Os *et al*, 2000) found that of over 7000 Dutch citizens, 17.5% endorsed at least 1 of the 17 positive psychotic symptoms listed on the Composite International Diagnostic Interview (WHO, 1990).

The observation of psychotic experiences in the general population has led to the development of a ‘continuum model’ (e.g. Claridge, 1997), which views psychotic phenomena as occurring on a continuum of severity throughout the population, from ‘normality’ at one end, to full-blown schizophrenia at the other. In this model,

psychotic *symptoms* are recognised as the severe expression of *traits* that are present throughout the general population. The idea that psychosis is continuous with psychological health causes the distinction between signs of mental illness (i.e. *symptoms*) and the expression of human individuality (i.e. *traits*) to become fairly blurred (Peters, 2001). The term used to describe this continuum is *schizotypy*, which is basically a personality trait analogous to other individual differences, such as the introversion-extroversion dimension (Eysenck, 1992). Schizotypal traits comprise human tendencies to have unusual perceptual or cognitive experiences and the capacity for divergent thought.

Schizotypy theory can be readily integrated with the creative problem-solving process with the hypothesis that higher levels of trait schizotypy are associated with lower thresholds of emotional stress required to trigger the problem-solving process. This should mean that high 'schizotypes' will experience creative insights, mystical experiences and psychotic episodes more readily than those who are less schizotypal (Jackson, 2001). Some evidence for this hypothesis can be found in large-scale statistical studies designed to examine the relationship between creativity and psychopathology (Post, 1994; Ludwig, 1995).

Felix Post (1994) gathered information on the lives of 291 world famous men (scientists, composers, politicians, artists, thinkers, writers), and scored them for the presence or absence of various psychiatric symptoms. He found that the lowest rates of symptoms were amongst the scientists (42.2%), with the highest being amongst creative writers (90%). A similar effect was found by Ludwig (1995) in his study of 1004 'eminent people'. His results showed a 73% risk of psychiatric disorders among those in creative pursuits (including 87% for poets), compared to 42% for all other professions. When Ludwig focussed on psychosis in particular, he found a greater prevalence in the creative arts (7%) than other lines of work (3%). The suggestion is that schizotypal personality traits can be expressed in both psychotic and creative acts.

Studies of schizotypal traits in religious populations (e.g. Day & Peters, 1999; Maltby & Day, 2002) have supported the idea that schizotypy may also be involved in mystical experience. White *et al* (1995) noticed that higher scores on the Francis scale of Attitude towards Christianity (Francis & Stubbs, 1987) were associated with

schizotypal personality traits, and Diduca & Joseph (1997) found religious preoccupation positively related to schizotypy among men. Day & Peters (1999) looked specifically at the schizotypal personality traits of individuals belonging to two new religious movements (NRMs), namely Druids and Hare Krishnas. They found that the NRMs scored higher than both Christian and non-religious control groups on questionnaires measuring positive symptomatology. Additionally, Maltby & Day (2002) found that mystical experience was associated with higher levels of schizotypy among both men and women.

The fact that schizotypal personality trait can be linked to all three kinds of experience (psychotic, creative and mystical) suggests they are all generated by a psychological process that is influenced by schizotypy levels. The cognitive problem-solving model certainly fits the criteria for such a process, while the additional concept of ‘oneness’ (unconstrued experience), as a proposed necessary component in the model, can explain the unusual, and often exhilarating sensations which accompany this process.

We have looked in some detail at the *psychological* function of oneness (and its associated problem-solving process), but have yet to consider its *evolutionary* function; i.e. why does this process exist at all? In fact, it is some of the evolutionary issues surrounding mystical and psychotic experience that have been taken as evidence *against* their assimilation (Hay, 1994). In 1965, Sir Alister Hardy hypothesised that ‘religious awareness is biologically natural to the human species and has evolved through the process of natural selection because it has survival value for the individual’ (Hardy, 1965). (This can be likened to the view of Carl Jung (1938/40), who posited an innate religious function within the psyche, implying that human beings are naturally religious). With reference to Hardy’s theory, Hay makes the point that mystical and psychotic experience cannot possibly be the same thing because psychosis is obviously *detrimental* to survival, (Hay, 1994).

Again, the concept of schizotypy (as a trait associated with both kinds of experience) can help to guide us through this evolutionary ‘paradox’. While high levels of schizotypy do indeed increase the risk of psychosis (which itself is counter-survival), this is not the trait’s sole function. Thus, the reason why schizotypy has not been ‘ejected’ by natural selection must be that it actually *benefits* our species in a different

way, and that the selective advantage of these beneficial effects must counteract the selective disadvantage of psychosis. We have already seen how mystical experience can have positively enhancing effects on people's lives, but perhaps less dramatically, schizotypy also provides the capacity for creative or divergent thought, which, within a basically focussed consciousness, is invaluable. This idea has been taken further by Daniel Nettle, who explores the survival value of creativity by considering it as, essentially, a sexual display used to enhance reproductive success (Nettle, 2001). The point is that schizotypal personality is actually *useful*, and to enjoy its benefits, we unfortunately must suffer its most extreme consequences from time to time.

THE APPRAISAL OF ONENESS

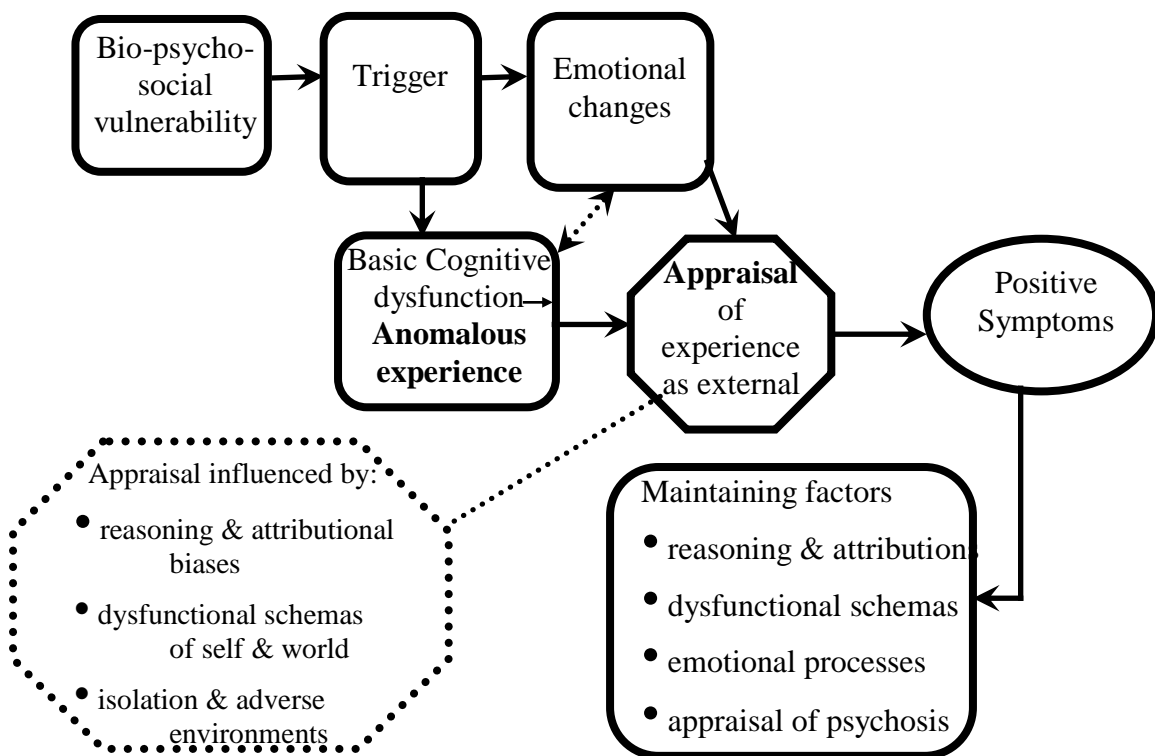
If we can accept the concept of 'proneness' to oneness experience as a function of schizotypy, we are now left with the question of which factors determine its outcome (i.e. whether it is a mystical or psychotic experience). We will argue that while the core experience is essentially the same, *appraisal* is key in determining *how* it is experienced (and subsequently integrated into an individual's cognitive and emotional makeup). This argument is grounded on the assumption that mystical and psychotic experiences involve not one, but two moments: the core experience, and then the inference. To clarify, it may be useful to return to our simplified three-step cognitive model: (i) *construct system breakdown*; (ii) *temporary suspension of constructs*; and (iii) *construct restructuring*. We have already established that step (ii) is where the experience (in its pure form) occurs, but now we can concentrate on step (iii), which is pivotal in determining *how* it is experienced. Following the perennialist train of thought, we would argue that step (ii) experience is completely free of any historical, cultural or social influences, and that it is not until step (iii) that the person perceives the experience through individually, and culturally tuned lenses.

This would explain the observed uniformity of mystical experiences within particular religious traditions, and would imply that the commonly 'religious' character of mystical experience is itself the result of individual interpretation. Such observations can be traced as far back as the work of David Hume (1711-76), who suggested that the religious sentiment is not inevitable. Rather, the religious aspect originates from the interpretation of certain impressions (cited in Prues, 1987). More recent

commentators have made use of Schacter & Singer's (1962) two-factor theory of emotion to examine the religious component of mystical experience. In this model, Schacter & Singer emphasise the requirement of both physiological arousal and a cognitive framework in the identification of an emotional experience. The implication is that experiences are not religious until they are identified and interpreted to be religious within a conceptual framework. On a similar line, Hjalmar Sundén claimed that religious traditions provide the templates or models that make religious experience possible, and that without knowledge of a tradition and its sacred texts, 'religious' experiences, as such, would not actually occur (cited in Holm & Belzen, 1995).

To find out if these ideas can also be applied to psychotic experience, we will consider some recent cognitive models of how the positive symptoms of psychosis arise (Garety *et al*, 2001; Morrison, 2001). One such model, which has been developed by Philippa Garety and colleagues, is outlined in Figure 1 below:

Figure 1: A Cognitive Model of the Positive Symptoms of Psychosis (Garety *et al*, 2001) (*my emphasis on 'anomalous experience' and 'appraisal'*)



This model postulates two routes to the development of positive psychotic symptoms: one in which cognitive changes give rise to an ‘anomalous experience’ (accompanied by an emotional response), which is then appraised in a particular way; and a second in which affective changes alone lead to a particular appraisal. For the purposes of this discussion, we will concentrate on the first route, which is said to be ‘the more common’ of the two (Garety *et al*, 2001). The suggestion is that a pre-existing bio-psycho-social vulnerability can be triggered to produce a ‘disruption of cognitive processes’, which then gives rise to ‘anomalous conscious experiences’. The cognitive disturbance can be viewed as a ‘weakening of the influences of stored memories’, leading to ‘ambiguous, unstructured sensory input’ (Garety *et al*, 2001).

This model can be tied in with what we have already established about the existential problem-solving process: ‘bio-psycho-social vulnerability’ (schizotypal proneness); ‘trigger’ (existential crisis & self-surrender); ‘cognitive disruption’ (construct system breakdown); and ‘anomalous experience’ (unconstrued experience of oneness). Importantly, the authors state that ‘at this point, however, these experiences have not been transformed into psychotic symptoms’ (Garety *et al*, 2001). So, it is not the anomalous experience *itself* which directly leads to psychosis, but rather the event that inevitably follows, i.e. the *appraisal* of experience (during construct restructuring): ‘The anomalous experiences, being puzzling and associated with emotional changes, seem personally significant and trigger a search for explanation as to their cause’ (Maher, 1988; Garety *et al*, 2001).

Garety *et al* suggest that the appraisal of experiences will depend upon pre-existing cognitive biases and expectations, and that if an *externalising* appraisal is reached for these experiences (‘which feel external in any case’), psychotic symptoms are likely to develop. Cognitive styles such as ‘jumping to conclusions’ and ‘externalising attributional biases’ are found to be elevated among deluded individuals (Garety & Freeman, 1999), and may therefore influence this appraisal process. In another cognitive model, Anthony Morrison (2001) similarly identifies the ‘misinterpretation’ of experiences (‘intrusions’) as leading to the development of psychotic symptoms. He suggests that the nature of an individual’s misinterpretation ‘will be determined by a combination of their experience, beliefs and knowledge’ (Morrison, 2001).

Both sets of literature (mystical and psychotic) clearly stress the importance of *appraisal* in determining how these ‘altered states’ are experienced. Therefore, continuing our central assumption that mystical and psychotic experiences are different aspects of the same experience (‘oneness’), we can now examine how oneness might be experienced and integrated in such radically different ways.

In order to do this, we must firstly consider the concept of Oneness. Although this concept is typically associated with Eastern religious ideology, it can be readily found in all mystical traditions of East and West, of ancient centuries, and of the present. Oneness, which may also be known as cosmic consciousness, refers to an awareness of the absolute interconnectedness of all matter and thought, or in the case of some traditions, one’s ultimate identity with God. The reason for drawing attention to the *concept* of Oneness is that it may help us understand how the *experience* of oneness is incorporated into people’s lives. The argument we make is that because Oneness has such profound metaphysical implications, the experience of oneness (from which the concept developed) will produce a metaphysical paradigm shift in the cognitive makeup of its experiencer. In terms of the problem-solving model, this paradigm shift will ‘solve’ an existential crisis, and then Oneness (the concept) will become incorporated into the construct system when restructuring occurs.

When oneness is experienced through spiritual practice, the individual will almost certainly have a *context* to provide meaning for the experience, thus allowing the development of a *structured* appraisal. For mystics, this state is welcomed and even longed for, and because it makes ‘sense’ (or at least complies with what they already know), the individual can manage the transition back to ‘normal’ (construed) reality fairly easily. They are then able to share their experience coherently with others, and to once again function effectively in society. Even if someone is not a mystic, but has some kind of religious affiliation or knowledge, they may still be able to structure their appraisal around the teachings of an established tradition. For the psychotic, however, oneness is experienced in the absence of a suitable context, and therefore its appraisal is dangerously open to suggestion. It may be that multiple (unstructured) appraisals are developed, which invariably make the transition back to ‘normal’ reality more difficult. With no meaningful context to fall back on, the individual finds themselves stranded, and grappling for explanations.

To conceive how the experience of oneness might be incorporated into cognition without the aid of explanatory frameworks, we must consider the basic implications of Oneness. Taken literally, the interconnectedness of all things would imply that all events (both physical and mental) are in *mutual causality*: i.e. everything is caused by, and causes, everything else. In this sense, every event can be seen to hold some kind of *meaning*; as it causes some other event to happen (i.e. it happens for a ‘reason’). Notice a subtle shift from the ‘normal’ perception of events (as being caused by the sum of past events), to a more speculative perception of events (as also being the cause of current and future events). The attribution of *meaning* to events will encourage one to speculate about what this meaning is, or *why* this event is occurring in terms of its current and future effects. Once an individual gets used to ‘figuring out’ the meanings of events, it may become a pre-occupation, or even an obsession.

Oneness (and mutual causality) also challenges fundamental principles about the temporal relation of cause and effect (that their onset is divided by a period of time). Therefore, if two simultaneous events with no ‘ordinary’ causal connection are seen to possess certain parallels, they may now be perceived as being connected (*meaningful* coincidences). This notion has been explored in detail by Carl Jung, who uses the term ‘synchronicity’ to describe the ‘temporally coincident occurrences of acausal events’ (Jung, 1952). Synchronicity differs from coincidence in that it implies not just happening ‘by chance’, but that there is an underlying pattern or dynamic that is being expressed through meaningful events. Both mystics and psychotics report an increased occurrence of such events, as is conveyed by the words of Peter Chadwick, who suffered a ‘mystico-psychotic crisis’ in the summer of 1979:

‘Cosmic consciousness and a belief in the unity and interconnectedness of all things easily bring with them superstitiousness and the noticing of coincidences’ (Chadwick, 2001)

The concept of Oneness also implies that the Self no longer has ultimate control over one’s actions and thoughts. The depersonalisation of actions may lead to the belief that there is a natural order to the universe and a predetermined course of events: i.e. a *destiny* or *fate*. In the context of Eastern (pantheistic) religions, fate will usually be understood in terms of *karma*, and in the context of Western (monotheistic) religions,

fate will be understood in terms of *God's guidance*. In psychosis, where there is no such context, fate might be understood as some kind of special mission (for a 'chosen one'), and the path of fate could have been laid by anyone, or anything; ranging from government intelligence agencies to aliens.

'Rather than thinking that these coincidences were magically, paranormally or cosmically engineered, a somewhat mystical view, I inferred that they (surely) must be engineered by people – a psychotic view' (Chadwick, 2001).

The depersonalisation of thoughts will confuse matters yet further. A loss of boundaries between self and others will mean that thoughts are no longer private: one is now able to read or influence other people's thoughts, just as others can read or influence theirs. Whereas the mystic will experience this in a positive light ('I am in touch with everyone'; 'there is a great harmony and oneness between all things'), the psychotic will experience this as intrusive and terrifying ('everyone can hear my thoughts'; 'people and the world are all together in communication against me') (Chadwick, 2001). To put it simply: in mysticism, Oneness is good; in psychosis, Oneness is bad.

CLINICAL IMPLICATIONS

Taking this proposed formulation of mysticism and madness forward, we will now consider the implications it has for the treatment (and possible prevention) of psychosis. The first important point to make is that we should not be attempting to eliminate the anomalous experience. The experience happens for a reason; it is a universal law of nature, and if we try to stop it, we would only be leaving additional problems unresolved. Rather than channelling all our efforts towards preventing these experiences (as is the focus of most drug therapy), we should instead be looking to nurture them, so that they can be appraised and utilised in a valuing way. We have seen that one potentially effective way of nurturing these experiences is within a healthy spiritual or religious framework. However, this kind of appraisal does not suit everyone, and as we can gather from the numerous cases of diagnosed psychotics with 'religious delusions', a religious context is not always enough to counteract the suffering.

So, instead of ‘preaching’ to an individual about the *spiritual* function of their experience, we may be far better off concentrating on its *human* function. This way, the course of treatment will be applicable to everyone, regardless of religious inclinations and beliefs. Indeed, the very notion that these experiences have a universal psychological function will itself act to *normalise* their occurrence. This can be highly liberating for someone who believed they were the only person with such experiences, or that such experiences automatically meant they were mad (Morrison, 2004). Moreover, if the undiagnosed population are subject to the same experiential states as the diagnosed population, then there would appear to be a greater hope for recovery. A *normalising rationale* is also a powerful tool in building the therapeutic alliance as it combats distress, reduces stigmatisation, and entails respectful listening to the client’s point of view before conclusions are drawn.

Under our model of psychosis, treatment would be targeted at helping the individual develop a healthy psychological appraisal of their experience. To do this, the therapist would firstly explore the client’s personal history (especially the events leading up to the experience), so that they can identify the initial ‘problem’ that needed resolving. Once this problem (or crisis) is brought to light, the therapist might comment on how the client’s original construct system may not have been equipped to resolve it. By continuously drawing parallels to the creative experience, the therapist can then explain how sudden insights or solutions can be achieved by breaking down existing constructs, and building new ones in their place. At all times, emphasis must be placed on the genuine, automatic and adaptive nature of this process. It should also be made clear that for the crisis to be adequately resolved, there must be a paradigm shift when construct restructuring occurs, and that the unusual, ‘noetic’ quality of their experiences is a necessary component of this paradigm shift.

This kind of understanding will provide meaning to the client’s experience in the context of their life as a whole. A meaningful appraisal should then help the individual return to a more ‘normal’ way of life, in a similar way to how mystics can meaningfully incorporate their unusual experiences. Also, because the psychological process is regarded as functional, the individual may be able to start working through some of the problems or crises that precipitated the experience in the first place. This will be particularly conducive in decreasing the risk of relapse.

‘The main thing is that when you can see the sense and meaning in the experience it is very different from the illness concept, which leaves you powerless and at the mercy of your experience and dependent on professionals. If you have sense and meaning, you can own the experience, be proud of it, and see it as a gift, and take control’ (Janice Hartley on her recovery from psychosis, in Hartley *et al*, 2006).

In the UK, there has been a growing acknowledgment of the importance of appraisal in developing and maintaining psychotic symptoms. Over the last decade or so, many theorists and clinicians have started to understand and treat psychosis by applying Beck’s (1976) original cognitive model of emotional disorders, which states that our *interpretation* of events will have consequences for how we feel and behave. Cognitive behavioural therapy (CBT) for psychosis is based on these same principles, and is focused on generating less distressing explanations for psychotic experiences.

Although CBT for psychosis is still in its early days, there has been promising evidence for its efficacy (Kuipers *et al*, 1997; Tarrier *et al*, 1998; Sensky *et al*, 2000). Tarrier & Wykes (2004) report that around 20 randomised controlled trials have now been published, and conclude that ‘overall there is good evidence for the efficacy and effectiveness of CBTp in the treatment of schizophrenia’. The impact has been such that the National Institute for Clinical Excellence now explicitly recommends that CBT be offered as a treatment option for psychosis (NICE, 2002).

The great success of cognitive approaches to the treatment of psychosis might be seen as a challenge to more conventional drug treatments. ‘Antipsychotic’ medication, as its name suggests, is designed to reduce or eliminate positive psychotic symptoms. Because psychosis is regarded as a biochemical disease, the drugs will act against psychotic experience by restoring the brain’s chemical balance. In cognitive approaches, the focus is shifted away from the psychotic experience itself, and onto the appraisal of experience. This complementary psychological understanding is not to deny a physical aspect; indeed, the case of facilitators (meditation, drugs, fasting, sleep deprivation etc) clearly demonstrates how experiences *can* be traced back to some form of physical sensory manipulation. It may be for this reason that many advocates of the cognitive approach would still hold a place for antipsychotic

medication in the treatment of psychosis. In our discussion, however, we have recognised that psychotic experience (whether physically based or not) might actually have an adaptive psychological function. We would therefore argue that its suppression by *unnatural* means (i.e. manufactured drugs) will interfere with our *natural* problem-solving processes. Moreover, even if psychosis were a brain disease, it is still hard to see the sense in risking further brain damage and dysfunction by administering powerful psychoactive chemicals.

As well as promoting the use of CBT as an adjunct to, if not replacement for drug therapy, our model will also have implications for the timing of treatment for psychosis. Since initial appraisals are likely to become increasingly consolidated over time, it is crucial that the healthy re-appraisal process is commenced as soon after the experience as possible. This is the logic behind early intervention for psychosis, which has rapidly become a key part in the modernisation of UK mental health services (DoH, 1998). In many countries around the world, there are now government-supported development programmes for a national implementation of early intervention services. The old Kraepelinian idea of gradual and inevitable decline has been replaced by a new belief that ‘psychotic breakdown is only one stage in the illness process, which can be prevented, delayed, modified and reversed’ (Johannessen, 2004).

CONCLUSION

This paper has shown how the experience of oneness (unconstrued consciousness) can induce significant cognitive paradigm shifts as part of an existential problem-solving process. We have argued that pre-existing beliefs, knowledge and contextual frameworks are necessary to negotiate this shift as one is able to make meaningful, structured appraisals. If, however, the experience is out-of-context, and appraisals are unstructured (e.g. patient A ‘drew assumptions’), the whole episode is likely to be overwhelming, confusing, and subsequently devastating.

By exploring the human function of this experience, we do not denigrate its possible spiritual significance, but instead bring psychosis in from the cold, stigmatising region of psychiatric labels. From a clinical perspective, the implications are huge because

psychotic content may finally be understood in terms of what has been going on in a person's life, family, and society in which they live. The client's 'insight' may no longer refer to whether the client agrees with the psychiatrist's position (e.g. that they have an illness), but to whether they actually understand *what* has happened and *why*. All the client really needs is a meaningful context; some way to pin their experience down and learn from it. The painfully inhumane narrative of dopamine overactivity in the mesolimbic pathway doesn't exactly breed insight.

The experience of oneness is a genuine human experience, available to all people. It occurs more readily among high 'schizotypes', and can be facilitated through substances and practices that act to loosen up the mind's constructs. We thrive off it for our spiritual and creative pursuits, but occasionally, when unprepared, we will slip into a fantasy world, clutching at whatever connections we can unearth. In many Eastern societies where experience of the mystical / psychotic realm is valued, people diagnosed with schizophrenia have a far better prognosis than in the modern Western world. If we were better educated about the validity and function of this experience in the West, we may be less overwhelmed when it occurs, and more able to utilise it as an important part of our psychological development. By placing mysticism and madness on the same experiential continuum, we can begin to lay greater value on its existence, and learn more about the fascinating experience of being human.

(10,121 words)

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