Religious Experience and Psychiatry: Analysis of the Conflict and Proposal for a Way Forward

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Religious Experience and Psychiatry: *Analysis of the Conflict and Proposal for a Way Forward*

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Abstract: Attempts to distinguish religious from pathological psychotic states have received considerable attention in the recent literature. It has been proposed that the distinction can be drawn in terms of subjects' evaluation of their experiences and ultimately outcome, conceived of as action enhancement or failure. Such an approach does not take in to account the contexts where the meaning of 'good' or 'bad' outcome are defined and hence are an overriding factor in subjects' evaluations of psychotic experiences. This suggests a need to examine the contribution of these contexts to the process of evaluation. In this paper, and with reference to an illustrative case study, I attend to psychiatry—an authority on unusual experience and belief—demonstrating an essential conflict between religious experiences and the assumptions and procedures of psychiatric practice. It is argued that the theoretical commitments of psychiatric science, the values embedded in the social dysfunction criterion, and a deficient understanding of culture promote the pathologization of unusual experiences and contribute to the generation of negative outcomes. I conclude with a proposed solution: by adopting an open-ended process of communication with the aim of achieving a degree of linguistic resonance among the involved parties, clinicians would be fostering mutual change rather than one-sided judgment. This would increase the chances of securing agreement and would put us in a better position to plan noncoercive intervention. Implications of the proposed approach for diagnosis and management of risk are discussed.

Keywords: spiritual experience, psychosis, harm, values, social dysfunction, cultural congruence, communication, linguistic resonance

The enlarging domain of psychiatric intervention is frequently associated with the undue medicalization of unusual experiences. In such a climate, it becomes of utmost importance to carefully choose appropriate candidates for the psychiatric gaze. This suggests a need to draw a distinction between religious experiences (with psychotic form) and pathological psychotic experiences. As Jackson and Fulford (1997) maintain, "*spiritual* experiences, whether welcome or unwelcome, and whether or not they are psychotic in form, have nothing (directly) to do with medicine. It would be quite wrong, then, to "treat" spiritual psychotic experiences with neuroleptic drugs, just as it is quite wrong to "treat" political dissidents as though they were ill" (p. 42). The distinction, however, is a difficult one to make.

As early as 1902, William James recognized that certain varieties of religious experiences share important areas of correspondence with psychotic ill-

ness (James 1902). He considered mystical experiences and insanity to spring from the same "mental level," where "seraph and snake abide there side by side" (p. 411). He wrote that there are certain features common to both states, such as a sense of ineffable importance in otherwise insignificant events, voices, visions, and control by external powers, but whereas in the former the dominant emotions are consoling, the meanings optimistic and the powers ultimately benevolent, in the latter the emotions are negative, the meanings dreadful and the powers malevolent (p. 410). James considered religious experience to come from a "wider self," a self-conscious, non-human life. A strategy James employed to support this notion was to consider the fruits of religious experience. On this account, the positive fruits of religious experience are an indication of its divine origin, and serve to separate these experiences from those associated with what he called 'insanity.'

The issue was revisited by the philosopher and psychiatrist M. Drury (1996), who acknowledged the similarity between some religious states and 'madness.' Drury, however, did not consider the 'fruits of the experience' to be sufficient for making the distinction, because that brings forth the intractable difficulty of deciding what consequences count as positive and according to whom.

We could consider the recent debate on this issue, specifically the influential account of Jackson and Fulford (1997), as an attempt to solve the intractable difficulty Drury alluded to. Jackson and Fulford (1997, 2002) maintain that we cannot make the distinction between spiritual and pathological psychotic phenomena (good and bad psychosis) by appealing to form or content of the experience and an account that places the experience in the agent's field of action becomes necessary. Good or bad from that perspective "concerns the way in which [the phenomena] are embedded in the structure of the values and beliefs by which the actions of the subjects concerned are defined" (2002, 388). In spiritual psychotic phenomena action is enhanced, whereas in pathological states there is a radical failure of action (Jackson and Fulford 1997, 55).

An important critique of Jackson and Fulford's account was put forward by Marzanski and Bratton (2002). They argue that spiritual experience should not be confined to the "benign and supportive" because that eliminates the suffering that, in some theological traditions, is recognized as an essential part of the (ultimately good) spiritual journey (p. 367). Spiritual experience, then, need not be action enhancing (in a materialist manner) and may in fact be associated with disempowerment of the subject. Furthermore, even if an anomalous experience is action enhancing that does not necessarily make it spiritual. The distinction between spiritual experience and "mental disorder," therefore, requires a "theological criterion" (p. 368). However, restricting such a judgment to theological criteria, as Jackson and Fulford (2002) maintain, "begs the question of whose theology we are to bring to the task—the client's, the clinician's, that of the wider culture, or that of the subculture?" (p. 389). This is a valid criticism, but the essence of Marzanski and Bratton's argument prevails: understanding what constitutes a good or bad outcome—in fact, the very meaning of good and bad—requires an appeal to consensual (and relative) values, and these values are—ultimately—over and above the subjects' evaluation of their own experiences. Even if an experience is action enhancing—within the framework of the subject's values and beliefs—we are still left with overarching contextual factors that determine how the consequences of these actions will be received, and whether such consequences will be considered 'good' or 'bad.'

Essentially, then, whether an experience is spiritual or pathological transcends the confines of individuals' incorporation of experiences in their framework of values and beliefs and involves a process of communication with their (sub)cultural group and—crucially—the relevant authorities (theological, medical, etc.). If we accept that, then the question is not "whose theology we bring to the task" but, more generally, what interpretative frameworks are available for the subject and how the aforementioned parties respond to those interpretations and to the consequent outcomes. In other words we must attend to *context* and to the process of communication as it is there that the experience is evaluated and the outcome determined. To the extent that this process is open ended and

aimed at securing some common ground among the involved parties, we can expect a convergence of values, a potential for positive outcomes, and—in a clinical context—the possibility of noncoercive intervention.

This paper, therefore, takes off where the aforementioned debate ends: the realization that an appeal to some independent authority (theological, medical, etc.) is an inevitable aspect of the process whereby experiences and actions are evaluated. Insofar as this is true, it becomes important to examine the assumptions and procedures underlying the practices of these authorities with the purpose of ascertaining their effects on the process. In writing this paper, I have two purposes in mind. The first is to examine psychiatry, an authority on unusual experience and belief. The diagnostic process in psychiatry frequently hampers the possibility for an open-ended process of communication for reasons to do with (1) the implicit prioritization of materialist values embedded in the psychiatric manuals' social dysfunction criterion, (2) a theory that remains secure in an empiricist/positivist framework, thus devaluing claims of alternative origins to (psychotic) experience, and (3) a misapplication of the cultural congruence criterion. These three factors—if not explicitly attended to—may be implicated in the generation of negative outcomes, of harm. Preceding the above is a brief case study of a young man undergoing what he believed to be religious experiences; the case will serve as a constant reference point to the ensuing discussion.

The second purpose in writing this paper is to propose a way out of this conflict. This requires a shift from assessing a verbal report of an experience in terms of its representational truth to thinking of it as a description that stands or falls according to how well it resonates with the wider community generally and the involved parties specifically. Within such a perspective, an open-ended process of communication conducted with the purpose of achieving a degree of linguistic resonance among the involved parties becomes an essential prerequisite for noncoercive, respectful intervention.

The Case of Femi

Femi is a 29-year-old man who was born in a West African country. He has been living with his father in the United Kingdom for the past 15 years. Two years before this episode, his mother left the family and returned to Africa, an incident that he insisted had no negative bearing on him. Before coming to the attention of mental health services, he was reportedly in good health and had no past medical or psychiatric history. His circumstances are no different from many other people of his age and social standing: after completing high school, he did a number of jobs until he finally settled in the sales section of a department store. He has several close friends and recently had been in a relationship. According to both Femi and his father, he has always been religious. He attended weekly sermons at a Pentecostal church in London, his father's church, and seemed inclined to adjust his life to Christian teaching.

Two months before admission, he began missing the weekly sermons and instead would spend long hours reading the Bible. He became disillusioned with his church, describing their sermons as "empty" and "uninspiring." Around that time, he got in touch with another church in his native country, one that emphasized a personal understanding of God through experience. He began a gradual process of isolating himself, engrossed in reading and listening to recorded sermons. He got rid of many of his possessions, justifying that by saying he wants to purify himself of material needs. He stopped going to work and made a habit of daily extended walks. He avoided going to his father's church, claiming that there is no point or value in going there anymore. Four weeks before admission, he began to have intense experiences where he would hear God talking to him, consoling, advising, and at times ordering him to get rid of his possessions. He began having a direct experience of the 'Spirit' in his body, to the point—at times—of feeling "taken over." He surrendered to these experiences and did not doubt their authenticity at any moment. His father was hugely concerned by these experiences and by what he described as an unexplainable and sudden change in behavior. He tried to dissuade him from pursu-

ing these new-found practices and appealed for support from the London-based church. His father and the church pastor considered Femi's behavior to be harmful, excessive, and not endorsed by the church. A few days before admission, he began a prolonged fasting episode to "further cleanse his soul." He was physically challenged by the fasting and was found confused and disoriented in a public place, upon which—after police intervention—an ambulance was called and a mental health act assessment arranged.

When he was assessed by the psychiatrist and social worker he said that for the past 4 weeks he had been in direct communion with God, that God had spoken to him telling him to get rid of his belongings, give up his job, fast, and change his life as a way of getting closer to 'Divine truth.' When the clinicians challenged the authenticity of the voice, he responded that he has no doubts it is from God, that he hears it in the space around him, and that it is entirely separate from his self. He also reported, upon direct questioning, that he sometimes experiences his actions as directly controlled by God, that occasionally his actual movements cease to be under his volitional control and are 'imbued with the Spirit.' This was particularly so on his extended walks: he would suddenly find himself embarking on a walk, and would literally feel the 'Spirit' moving his body. He said that he finally understands what God is and felt on to something significant in his life. He was considered to present with second-person auditory hallucinations, command hallucinations, volitional passivity, and significant risk to self in the context of recent social/occupational deterioration and in the absence of validation by his father and the church and was consequently placed under section '2' of the mental health act.

After admission, he continued to resist all forms of treatment. He was unable to grasp the reason for his incarceration and considered the whole process to be a test from God. One week into the admission and after mental state assessments and nursing observations confirmed the persistence of the previously mentioned psychotic symptoms, the clinicians were convinced that a diagnosis of 'acute psychotic episode' is justified, upon which treatment was enforced on him. A number of days later, he finally accepted treatment, and 2 weeks after that he acknowledged, for the first time, that he might have been ill. In terms of his symptoms, he no longer heard the voice of God, no longer felt the expectancy of a major change in his life, and was transformed to an unsure young man: unmotivated and apathetic.

Justifying Psychiatric Intervention: Social Dysfunction and the Absence of Cultural Congruence

According to the DSM-IV (American Psychiatric Association [APA], 1994) the presence of psychotic symptoms (Criterion A) and social/occupational dysfunction (Criterion B) are sufficient to warrant one of the different 'Schizophrenia group' diagnoses. In the absence of social dysfunction an individual experiencing psychotic phenomena does not, by definition, 'have' a disorder and would probably fall some where along the psychosis continuum with a designation of 'benign psychotic experience.' In Femi's case however, the presence of social/occupational dysfunction is obvious, at least if we subscribe to the DSM-IV's definition of dysfunction: "for a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset" (APA 1994, 285). In his case, we have dysfunction in all of these areas: he stopped work, gave up seeing his friends, and fasting compromised his health. Functional deterioration in his case was probably a result of several factors: profound engagement in his experiences, a direct consequence of hearing the voice of God telling him to do certain things, and the alienating response of his father and the London church. The inclusion of Criterion B in the DSM-IV serves the function of isolating 'bad' or 'harmful' psychotic experiences. However, does the presence of social/occupational dysfunction justify psychiatric intervention in his case? If we have a closer look at 'Criterion B,' we can uncover the following assumptions. (1) Social dysfunction is some how related to the psychotic symptoms. (2) Social dysfunction is equated with harm (for

now broadly defined as an experience of suffering or incapacity). (3) The origin of harm can be traced back to the person. Let us consider these assumptions.

In certain cases, the relation between social dysfunction and psychotic symptoms seems straightforward. A previously well-adapted and functioning individual who has consistently succeeded in interpersonal relations, academic and occupational performance, and who develops psychotic symptoms while simultaneously deteriorating in all these aspects can be fairly judged to have done so as a consequence of the symptoms. A psychiatrist then, it could be argued, is entirely justified in treating a 'paranoid psychotic,' just as they are justified in treating Femi. The story would go like this: A person presents with psychotic symptoms in the context of functional impairment, functional impairment is equated with harm, we therefore have a 'problem' that requires intervention, and because the culprits are the psychotic symptoms we need to treat those symptoms, hence psychiatric intervention to treat the psychosis. The problem—diagnostically speaking—lies at the stage where the presence of 'harm' is established. This is where the lines are drawn as to who is or is not appropriate for psychiatric intervention.

A second factor justifying psychiatric intervention has to do with the absence of cultural validation. The inclusion of 'culture' in the DSM-IV as one of the issues to attend to in diagnosis no doubt reflects the authors' commitment to constructing a manual with universal applicability. Beliefs and experiences that are considered normal (or at least permissible) by a certain culture should not be considered pathological even if they are phenomenologically similar to the psychiatrists' delusions and hallucinations. Hence, the various warnings scattered throughout the DSM-IV: religious beliefs are not delusions if "ordinarily accepted by other members of the person's culture or subculture (i.e. it is not an article of religious faith)" (APA 1994, xxiv), and "hallucinations may . . . be a normal part of religious experience in certain cultural contexts" (APA 1994, 275). Although we can regard hearing God's voice or seeing the Virgin Mary as, respectively, auditory and visual hallucinations, we should not consider them pathological if they are a normal part of religious experience in certain cultures.

'Cultural congruence,' as I would call it, relegates the judgment of the presence of psychopathology from the psychiatrist to the cultural group. In the case of Femi, this entailed consulting his father and the original Pentecostal church and asking them if his experiences and behavior are normal or abnormal by their own standards: they confirmed the latter. This seems to satisfy the DSM-IV's cultural congruence criterion and adds to the conviction that Femi is 'ill.' Furthermore, the absence of cultural validation—in this account—is implicitly linked to harm by virtue of the fact that experiences and beliefs that fail to elicit the approval of the patient's cultural peers must be abnormal and therefore—by definition—harmful.

Far from assisting clinicians in detecting the presence of harm, however, these two fundamental aspects of the diagnostic process—as I argue below—may in fact contribute to the generation of harm, rendering pathological what might have been otherwise. Before considering how this may come about, we need to elaborate the notion of 'harm.'

Generation of Harm and the Conflict between Religious Experience and Psychiatry

Harm and the Origin Thereof

Harm can, of course, be inflicted on others. This is not my concern; harm to others brings about a wholly different set of considerations, mainly moral and legal, and is not the topic of this paper. My focus is on harm that affects a person. Harm—for our purposes—can be broadly defined as an experience of suffering (excluding suffering that is imposed by others): social isolation, inability to perform desired actions or pursue goals, failures at projects one undertakes, direct threats to physical integrity and so on. Harm can be more specifically defined as a *negatively evaluated experience of incapacity*, where incapacity is defined as a failure of intentional action (Jackson and Fulford 1997, 54). There is, therefore, the possibility that functional failure (objectively determined) may not coincide

with harm if the experience of incapacity is positively evaluated. In physical disorders, however, 'functional failure' and 'action failure' usually coincide, which excludes the need to separate both (Jackson and Fulford 1997, 54). A fractured femur constitutes a functional failure and results in incapacity, the experience of which will most likely be negatively evaluated by the subject, hence the presence of harm.

With psychotic phenomena, however, there are different matters to consider. Psychotic phenomena are not pathological in themselves: if we consider psychotic phenomena (including certain religious experiences) as part of an adaptive problem-solving process that gets activated at times of "existential crises" to resolve the tension that acted as the trigger by offering new insights or a "paradigm shift" for the individual (Jackson 2001, 2007; Jackson and Fulford 1997), then we no longer need to look for 'pathology' *at* the origin of the symptoms but, rather, at what is done with them (what the consequences are). We cannot, therefore, talk of functional failure as the mark of pathology and, as Jackson and Fulford (1997) argue, an 'action failure' account becomes necessary.

According to an influential model (Frith 1992; Frith and Done 1988), psychotic phenomena involve a reduction in agency and that, by the definition stated, involves incapacity manifest in subjects' inability to recognize their self-generated thoughts, actions and intentions as their own.[1] The manner whereby such experiences are evaluated determines whether action enhancement or action failure (and therefore harm) ensues. Such an evaluation depends on how the experience is "*embedded* within the framework of values and beliefs of the individuals concerned" (Jackson and Fulford 1997, 54). The manner a person evaluates a psychotic experience depends on their preexisting values and beliefs and, crucially, on context and response of others; and that includes the values and beliefs of all those involved. These factors all influence outcome and determine whether the subject's experience of incapacity is negatively or positively evaluated and, therefore, whether action failure or enhancement results. 'Harm,' then, is a consequence of the interaction of several factors and hardly, as the DSM-IV seems to implicitly assume, secondary to a pathological cause to be found *in* the person (1997, 52).

Returning to the case of Femi, we would find that social/occupational dysfunction as defined in the DSM-IV did exist from the outset. Harm, however, came into the picture and was firmly established after his involuntary hospitalization and forced treatment. As far as Femi was concerned, his *negatively evaluated experience of incapacity* began when he was locked in hospital.[2] Obviously, restricting someone's physical freedom results in suffering, but in his case there was the additional invalidation of his experiences and the manner where by he was forced to abandon his religious project. That is most evident in this utterance after several days of treatment: "You say I am ill and the voice I am hearing is not from God. Am I ill?" His experiences, thus, have become a *problem* for him. The response of the psychiatric authority and to a lesser extent his father (despite Femi's initial resistance) transformed what was a positively evaluated experience to a negatively evaluated experience; there lies the origin of harm. Now I am not denying that Femi and other people undergoing intense religious experiences do need support and help, the question is where they should get it from. In another context, Femi might have received support from a religious community, one for example that respected the value he attached to the experience while understanding that he was particularly vulnerable at that time.

But let us go back to the situation at hand: the crucial moment in a person's psychiatric admission is when harm is judged to be present. And as I mentioned, harm is a consequence of several interacting personal, social, and contextual factors. That there is—at the origin of harm—a conflict between the involved parties is to be expected but that this conflict goes unexamined and the patient is considered the 'problem' is a recipe for forced treatment and the like. Furthermore, when a person is 'in' the psychiatric system, harm is no longer the determining factor; their mental state is scrutinized and any beliefs or experiences judged to be abnormal are subjected to change. The moment of assessment and diagnosis is therefore crucial. Here is Derek Bolton commenting on how

the process of diagnosis should be, at a time when we are realizing the social (as opposed to biological) nature of mental disorder:

> What appears now is fundamentally a matter of personal and social values to be negotiated by various stakeholders. The implication of these changes in assumptions is that in assessment for treatment the primary focus would not be identification and diagnosis of 'disorder' but rather negotiation of values and motivation for change. (Bolton 2004, 3)

The task in the remainder of this section is to elaborate the various sources of the aforementioned conflict as they unfold in the diagnostic process. The first set of problems is directly related to a conflict of values, a conflict encouraged by the empiricist/positivist nature of psychiatric theory and by the prioritization of materialist values over values associated with religious accomplishment. The second set of problems is related to conflict arising from the misapplication of the cultural congruence criterion. The implication of these sources of conflict for the patient are invalidation by the involved parties and in certain cases inappropriate hospitalization, two factors that thwart the potential for a positive evaluation of psychotic experience and are, therefore—if we accept that harm is a consequence of several interacting personal, social and contextual factors—directly implicated in the generation of harm.

A Conflict of Values

Here's a story.

> A man saves another man who was sinking into a slimy pond, thereby risking his own life. Now they are both lying on the edge of the pond, out of breath, exhausted. The rescued man says: "You idiot! Why did you do that? I live in there!" (Tarkovsky and Guerra 1983)

The conflict can be broken down to two strands: (1) A disagreement on the proper description and true origin of what he experienced, and hence the value of that experience. (2) A disagreement on the priority of religious values over values associated with social and material accomplishment.[3]

The Value of Experience (and a Digression on Explanation/Understanding)

Karl Jaspers' (1959/1997) distinction between explanation and understanding was an attempt to separate the search for *causes* from the quest for *meaning*. It was also an attempt to preserve a domain of objectivity for scientific facts and to distance this domain from that of values: scientific inquiry should not be subject to the whims of us humans; the project of science should not depend on what we consider worthy, beautiful, or important. These distinctions have slowly collapsed along the decades and we are now at a point were we must face the intrusion of values in our scientific endeavors and acknowledge the validity of other interpretative disciplines in understanding the world. The story of this collapse is a long and winding one (see, for example, Fulford 1996), and I will not attend to it in detail. The implications are, however, significant; here is Peter Bracken:

> Because natural science has been shown to progress on the basis of certain historically and socially grounded 'choices' it has been argued that it, like the disciplines classified as human sciences, also contains a hermeneutic dimension. (1993, 267)

We simply can no longer afford to maintain a strict separation between facts and values, nor is a simple reduction of one into the other helpful in any sense. Such a reduction, as Fulford explains in relation to psychiatry, means that mental disorders will either be conceived off wholly as moral categories (e.g., Szasz 1960) or as value-free disease categories; as biological psychiatrists would want them to be (Fulford 1996, 14–15). What we need to do is to tolerate what Littlewood (1996) calls an "ironic simultaneity": neither explaining (as the uncovering of facts) or understanding (as the elaboration of values) is completely true or completely false; both approaches may be "taken as a valid map of reality, constructed for a particular purpose, and each remains grounded in its customary procedures whilst entailing the other" (p. 191).

Psychiatric theory, however, remains embedded in an empiricist and positivist framework. The elimination of values from our understanding of mental illness is not just philosophically untenable, but can also seriously hamper our ability to understand the experiences of others. This is because in psychiatric theory we find a species of explanation that is wholly reductionist, which allows no meanings to be associated with the experiences of people (apart, of course, from the

meanings and hidden values associated with the reductionist explanations themselves). But what other species of explanation are there?

Proudfoot (1985) distinguishes between explanatory and descriptive reduction. In explanatory reduction, we are "offering an explanation of an experience in terms that are not those of the subject and that might not meet with his approval" (p. 197), but we are still identifying the experience under the description by which the subject identifies it: what we are trying to explain is precisely the experience of 'hearing the voice of God' and not a biochemical imbalance or a hallucination. Explanations that attempt to account for a religious experience in terms of the phenomena of the natural world are of this variety. These explanations might leave the theological aspect of the experience unaffected.

When Durkheim (1965/1976) was writing about religion, he was not claiming that religion is *nothing but* the projection of the power of the social order over a deity; he was trying to explain why religion holds power over people by avoiding reference to any supernatural explanations. But his explanation still left room for God, religious symbols, ritual, practice, and, of course, religious experience. We might agree or disagree with Durkheim's explanation; his explanation stands or falls according to how well it accounts for the evidence. That leaves his explanation on a par with those derived from psychology, anthropology, physiology, and even theology. Theologians, for example, can agree with naturalistic explanations without feeling threatened in any way. After all, they can simply assert that God works through the phenomena of the natural world and an exhaustive naturalistic explanation does not preclude His influence (Griffith-Dickson 2000). Strategies that invoke 'explanatory reduction' do not eliminate the possibility of 'meaning-seeking' on behalf of the subject. That is for two reasons. (1) The experience is identified in the subject's own terms; that is, it still is an experience of God. (2) The explanation leaves room for the experience to have a theological value.

Descriptive reduction, on the other hand, is when an experience is identified under a different description from that of the subject. As Proudfoot (1985) maintains, "to identify an experience in nonreligious terms when the subject himself describes it in religious terms is to misidentify the experience, or to attend to another experience altogether" (p. 196). To describe Femi's experiences of hearing the voice of God by reference only to 'biochemical imbalance' or 'hallucination' is to mis-describe and "lose the identifying characteristics of those experiences" (Proudfoot 1985). Such explanations purport to give the origin or cause of the experience and tend to limit its meaning and significance to that; biomedical explanations of psychiatry are reductionist in this sense.

This is clearly evident when we consider the centrality of the form/content distinction in psychiatric diagnosis; form is what is essential to diagnosis in psychiatry (Sims 2003). The content of Femi's assertion that he is hearing the voice of God was considered irrelevant to the diagnostic process, but the form—here a hallucination—was the key to supporting a diagnosis of 'psychotic episode.' Content, on the other hand, is variable; a factor of the patient's beliefs and cultural background. The assumption in psychiatry is that form is universal and, ultimately, reducible to the biopsychological phenomena. But in redescribing his experiences in terms of an 'abnormal form,' we have certainly lost the identifying characteristics of the experience and are dealing with something else altogether. This may hamper any further understanding of his experiences, an understanding that can inform us why he (specifically) had an experience of hearing the voice of God (not just a hallucination) at this time and place. Such an understanding can certainly include 'biological changes,' just as it could include biographical, social, historical, and cultural factors.

A descriptive reduction carries the implication of sabotaging his own attempts at finding meaning in his experiences. When considering a religious experience, we cannot separate the value or meaning of the experience from the perceived cause of the experience (in this case explanation *and* understanding are opposite sides of the same coin). For Femi, the voice he heard came from God and the value of the experience cannot be separated from that. His experiences were, initially, interpreted as action guiding and positive insofar as they came

from God, especially if you consider, as he did, that whatever comes from God is *intrinsically valued*. But they were also extrinsically valued because the consequences where expected to be positive.

From a psychiatric point of view, he was having a 'psychotic episode,' proximally caused by a 'biopsychological disturbance.' Furthermore, this assessment of the 'true' cause of his experiences was considered to be a matter of scientific fact and certainly not subject to the values of psychiatric science. After all, as a science, psychiatry is dedicated to the discovery of the supposedly objective, universal, and secular reality of mental illness. There are problems with this position: we can only speak of 'biopsychological disturbances' after we have isolated the subject matter for intervention, here the psychotic symptoms. But the judgment that these symptoms are pathological has already been made on other grounds. As Bolton (2000) maintains, a judgment of disorder is usually made through social unacceptability or "radical incomprehensibility," whence then the talk of 'biopsychological disturbance'? At most we can only talk of a number of factors (social, political, cultural, psychological, and biological) that resulted in this patient sitting in this room with that psychiatrist at a certain time and place. The notion of a 'biopsychological disturbance' is not a value-free one; it is invoked to account for what are essentially socially undesirable or un-understandable behaviors or beliefs, the negative evaluation of which is then transported to the theory of the probable cause of the offending behavior or belief. The use of the word 'disturbance' is therefore a reflection of a relative/negative social judgment and not of an objective and value-free state of affairs.

If we insist that his experiences are caused by 'biopsychological disturbances,' we are exporting the value we attach to the supposed true cause of the experience on to the experience itself. In essence, it's a process of value imposition. Let me explain. Consider a building; you can attach to it certain aesthetic values pertaining to form, beauty, elegance, and simplicity. But then you learn that contrary to what you thought, it was not built from natural mud bricks (a material you consider beautiful), but is made from prefabricated panels (a material you consider inferior). Would that change your aesthetic evaluation of the building as a whole? It might, even though the building is still beautiful and elegant by your own criteria. The way we value an experience or an object, however, is frequently affected by what we believe to be constitutive of it. In considering an experience to be caused by a 'biopsychological disturbance' we are, by definition, devaluing the experience. And in hospitalizing and treating a person like Femi, we are forcing the negative value we place on the experiences on to him.

A Matter of Priorities: Religious Transformation Versus Social/Material Accomplishment

The DSM-IV (APA 1994) specifies work, interpersonal relations, and self-care as three areas that should feature in an assessment of function. These factors have been taken somewhat too literally by certain drug manufacturers who feature in their drug promotion advertisements a colorful graphic illustration of 'functional impairment': a wallet, a teddy bear, and a shaving razor; presumably denoting work, interpersonal relations, and self-care, respectively. Hathaway (2003) suggested adding other areas of functioning, specifically we should include 'clinically significant religious impairment' as another area of functioning that could be compromised by mental disorder. Clinically significant religious impairment is defined as a "reduced ability to perform religious activities, achieve religious goals, or to experience religious states, due to a psychological disorder" (p. 114).

But why should we stop there? After all, there are so many other areas of functioning that matter to people but are not included in the DSM-IV. Wouldn't mental disorder affect a subject's ability for aesthetic appreciation? The point I am trying to make is that the inclusion of these three areas in the DSM-IV assessment of function must reflect certain values as to what matters in life, which in this case are inherently materialist. The question then becomes if there are cases where these values must be suspended to allow for potentialities that are valued in a different context. Or, to be more precise, should religious transformation be allowed to continue even if it results in functional deterioration as defined by the DSM?

It is well known that intense religious experiences and involvement can result in social isolation, absence from work, and deterioration in self-care. Ascetics are actively encouraged by many religious traditions to forego material and social accomplishment. There is no question of outcome here; or, more precisely, the outcome does not have to be measured in terms of material success or social achievement. That is, we cannot assess whether an ascetic should be allowed to continue in her way of life only if that way of life can yield positive outcomes. That is an empirical question and can only be answered with reference to a certain set of values and with the benefit of hindsight. It might be the case that, according to her (and maybe her religious tradition), the positive outcome is to get 'closer to Divine truth' at the expense of all forms of social and material accomplishment.

If we existed in a culture that allowed 'experiences on a journey,' the situation with Femi might have been different. For better or for worse, he might have been encouraged to pursue his religious goals and maybe even supported through his intense experiences. That, however, would not have been possible. At the heart of the DSM-IV's functional assessment is an implicit prioritization of a set of values that reflect a material (as opposed to spiritual) outlook on what *should* matter in life.

In objection to this line of thought, it could argued that 'religious experiences and transformation that result in social and occupational dysfunction are only unvalued if they are associated with a mental disorder; the critical point is to determine the presence of disorder. If the ascetic I am referring to above has a mental disorder, then we have grounds for treatment.' But that is exactly the problem: as I have attempted to show, the judgment of disorder is affected by the values implicit in the diagnostic manuals, the values of all those concerned, and the theoretical commitments of psychiatry. When these values and commitments are made explicit, there might not be disorder in some cases of 'mental disorder.'

Misapplication of the Cultural Congruence Criterion

> They called me mad, and I called them mad, and damn them they outvoted me. (Nathaniel Lee, quoted in Porter 1991)

To be able to apply the cultural congruence criterion, clinicians need to (1) determine a relevant cultural reference point, (2) seek the judgment of cultural peers, and (3) accept the assumption that absence of cultural validation is sufficient to declare pathology. There are problems with each of these points.

How Do We Determine a Subject's Cultural Group?

It is important to have a vision of what 'culture' is before we can talk of a 'person's cultural group.' We can consider culture as "shared symbols and meanings that people create in the process of social interaction" (Jenkins and Barrett 2004, 5). Our experience of the world and of our selves, our interpretations of events, and our orientation in action and thinking are all mediated and shaped by culture (Ibid). Culture, therefore, includes religion, as it does all other symbolic institutions. But these symbols and meanings are not static, reified entities and neither is the human agent. The interaction between people and symbols at the cultural level is characterized by reflexivity; it leaves both changed. Shelly Ortner (1996) captures this accurately in her account of the process whereby cultural groups such as 'women' and 'minorities' are created. Such cultural categories or "historical subjects" are constructed and subjected to the "cultural and historical discourses within which they operate." The human agent responds to the world as given to them and could enact, resist, negotiate, and ultimately—possibly—change the world and re-produce new cultural categories. But in so doing they also define themselves and negotiate their own personal identity.

If we consider the DSM-IV cultural congruence criterion, we would find that the sense in which culture is used is, roughly, that of a 'label': if subject A belongs to culture A, then should her experiences violate the standards of culture A, we can make a judgment of pathology. Two things need to be presupposed if such a criterion is to be of any value: (1) that there is a well-defined, circumscribed cultural group that would serve as a reference point, and (2) that the subject is a perfectly well-adapted member of that group. How can we determine that? In the case of Femi, for example, there are multiple cultural influ-

ences: there is his native West-African country, Pentecostal Christianity (different churches), and the influences of being a West African living in London. To be able to judge whether his experiences are normal or abnormal by appeal to cultural congruence, we need to examine all the cultural influences he had been subjected to and determine to what degree he accepted, imbibed, resisted, or negotiated these influences. Interestingly, in his case, the church he had been in contact with in his native country did consider his experiences to be a normal part of spiritual development and actively encouraged him. Then again, if we embrace this fact and consider his experiences to be normal we would be negating all other cultural influences in his life.

Broad-brush cultural categorizations are insufficient to determine a person's cultural belonging. Even minor exposures to different cultures can induce significant changes in a person's basic sense of self to the extent of affecting core self-processes such as thinking, feeling, and agency. A recent demonstration of this—in the case of psychosis—is in John Barrett's (2004) work with the Iban, an indigenous people of Malaysia. Barrett found that thought insertion was not part of the Iban psychotic experience. He demonstrated that the Iban concept of thinking is very different from that found in the 'West,' and that the distinction between thought and speech is not as explicit. Despite a culturally sensitive re-translation of the PSE-10 (the Present-State Examination), the idea of 'thought insertion'—of other beings knowing your private thoughts—was nonsensical to the Iban and was not part of the psychotic experience (2004, 95–99). Interestingly, Barrett interviewed subjects from the Iban population who were suffering with psychosis and who have been exposed to education and Christian teaching. He found that these subjects did experience thought insertion. The hypothesis he suggested was that these subjects have been exposed to a cultural context (the experience of an omnipotent, omniscient God) in which it was possible that private thoughts can be known by an outside entity (2004, 103).

The point is that the power of the cultural congruence criterion collapses once we consider the interaction between subject and culture to be a reflexive process that can fundamentally alter the person's experience. If we classify a person as a member of a specific cultural group, we would be disregarding all the other influences he/she had been exposed to, and at a time where multiple cultural influences are available in our social worlds this is simply untenable. To be able to use culture as a reference point, we need to engage in a painstaking examination of the myriad influences a person has been subjected to, only then can we begin to make a fair judgment.

The Commitments of the Cultural Group and How That Shapes Their Judgments of Normality/Abnormality

Before we can accept the opinion of the father or the church with regards to the abnormality of Femi's experiences, we need to consider what commitments they bring to the process. Femi's father, himself a very religious man, did not worry too much about how we, the psychiatrists, would treat his son. He wanted him "back to how he was," and that entailed resuming church attendance with him, going to work, helping with the expenses, and so on. This reminds me of a brief case study (Littlewood and Lipsedge 2004) of Chaim, a 14-year-old boy in an ultra-orthodox Jewish family in London. His parents considered his withdrawal from reading Talmudic texts and his un-orthodox beliefs and wishes to be a sign of mental illness. The family doctor (who was an orthodox Jew himself) concurred and was convinced the boy had schizophrenia. On further examination and on visiting the household, the authors found that the problem lies in the conflict created by the boy's wish to transcend the narrow limits of ultra-orthodox life and to pursue different lifestyles offered by the wider community he exists in. For his deeply religious parents, that wish was in itself a sign that their boy had gone 'mad.' Chaim's family and Femi's father had a huge investment in wanting their children to return to how they were. The transgressions committed by Chaim and Femi were never seen as alternative possibilities that could be pursued; rather, the thought of a radically different way of life became, for the families, the conviction that their children were ill. Essentially, then, there was a conflict of values between the family and the child committing the transgression, a conflict immediately obscured the

moment the child was nominated as the source of the problem and considered ill.

The church itself has its own commitments. In asking Femi's original church if his experiences are abnormal, we are in effect asking them to tell us whether they consider his religiosity to be healthy or unhealthy (where unhealthy, in this context, usually means 'a consequence of mental illness'). As Littlewood and Lipsedge (2004) point out, it has not always been a task of a church to make a distinction between healthy and unhealthy religiosity; in fact, they argue, it is quite a recent development. Larger churches do not want conflict with the domain reserved for science and aim at 'accommodating' the opinions and judgments of medical professionals (Littlewood and Lipsedge 2004, 187). Smaller sects, however, consider the move to accommodate medicine as a threat and are willing to take matters of healing in to their own hands (Ibid.).

Here, then, we can partly understand why the London-based church considered Femi's experiences abnormal, whereas the church in his native country—isolated from the political influences in an advanced capitalist nation—encouraged him. Surely their 'theological criteria' for judging religious experiences differed but also, and importantly, the contexts within which the two churches operated were different and that carried with it different commitments that affected their judgment.[4]

Where Should We Look for "Congruence"?

Congruence is present if members of the cultural group validate the experiences and beliefs of the subject. In the case of Femi, both his father and the London church considered his experiences (of hearing the voice of God and feeling controlled by God) to violate the boundary of 'allowable' experiences, even in a religious context. I argue, however, that in assessing congruence we should not be confined to mere validation or otherwise by the group, and must consider, instead, whether the experiences are permissible within the culturally accepted epistemology. Let me explain.

Here is a brief account of the beliefs of the Lakota tribe, a Plains Indian tribe:

> Any encounter with a deceased relative is construed by the Lakota as a sign of misfortune, usually a warning to prepare for one's approaching death. . . . When a person hears the ancestral voice, he or she is called by name or by the appropriate kin term. . . . In some cases, the voice says, "Come!" . . . Usually, however, the person who hears the voice prepares, together with his or her kin, for his or her death. (Spiro 2001, 222)

It is culturally normative for the Lakota to hear the voice of the deceased. This would seem to be a paradigmatic case of the kind of experiences and beliefs that the DSM-IV wants us to save from the label of 'psychopathology.' Indeed here is the DSM-IV sourcebook:

> Many Plains Indians [the Lakota are a Plains Indian tribe] hear the voice of a recently deceased relative calling them from the after-world. The experience is normative and without pathological sequelae for members of these communities, and therefore by definition cannot be abnormal. On the other hand, for an adult white North American, it might well be a hallucination with serious mental health consequences (Kleinman et al. 1997, 868–869)

This account brings forth two questions: why is the Lakota-Indian experience of hearing the voice of a deceased relative normative? Why is a similar experience in a white North American pathological? The maintenance of such an experience in the Lakota Indians points to two things: that the experiences are constituted in different individuals through similar routes, and that they are permissible within the culturally accepted epistemology. The Lakota Indians believe in an afterworld, they believe that deceased relatives and ancestors can communicate to them in this world, they believe that this communication can be a voice, and when that happens they consider themselves to possess a piece of information from the afterworld, they then act accordingly. Hearing the voice of the deceased is therefore not only possible on a wide-scale among them, but is also entirely normative as it falls within their own epistemological boundaries.

On the other hand, encountering a white North American having a similar experience usually evokes worry in most of us. Her experience violates our deeply held epistemological convictions and represents a clear error. Similarly, a Lakota Indian who reports hearing the voice of his (living)

absent son might be considered by the group to be having an abnormal experience: their epistemology accounts for a deceased relative talking to you, and not for hearing the voice of living people when they are not around. I would, therefore, argue that in assessing the cultural congruence of an experience we should go beyond mere validation and try to consider whether it is permissible within the epistemology of the cultural group. If group A believe in a supernatural order and allow that God can talk to people and at times control their actions and thoughts, then surely a subject—whom we have good reason to believe is an adapted member of group A—having precisely those experiences cannot be considered to be culturally errant.

I can be accused, however, of conflating belief and experience. It could be argued that although it is normative for group A to believe that God can talk to people, it is nevertheless still abnormal to have a psychological experience of hearing God's voice. Melford Spiro (2001) makes this point in relation to the Lakota Indians and argues that although the Indian's belief in ancestors calling from the afterworld is culturally normative, the actual experience of hearing a voice is psychologically abnormal because it "confuses an event in the inner world with one in the outer world" and "constitutes a failure in reality testing" which in his view makes the experience itself pathological "whatever its sequelae" (p. 223).

Spiro seems to be making two errors here: first, he assumes that belief and experience are wholly independent entities and fails to appreciate that experience is constituted in large measure by pre-existing beliefs and concepts (Proudfoot 1985).[5] It is unlikely, for example, that the Lakota Indians would hear the voice of deceased relatives had it not been for the prior existence of beliefs in the afterworld and the ability of ancestors to communicate from it. Hence, it is a contradiction to say that the belief is culturally normative while the experience (which is in large measure constituted by the beliefs) is abnormal.

Second, he is importing the assumptions of a certain epistemological tradition and applying them in a different culture as universal standards the violation of which is sufficient to constitute pathology. Of course, Spiro's motivation is to oppose normative cultural relativism by arguing for universal, extra-cultural (here scientific) standards for judging experience. But in doing so he is missing the point: what makes an experience 'pathological' or 'abnormal' is in large measure a complex judgment that involves social and cultural norms, the response of others, the appraisal of the subject, the values of all those involved and finally the outcome of the experience. It is not a detached judgment that can simply be made by appeal to some universal standard according to which 'the confusion of an event in the inner world with one in the outer world' is sufficient for pathology.

With this understanding of cultural congruence at hand we can reconsider Femi; are his experiences culturally congruent? To answer this question, we need to examine his cultural groups' beliefs and the epistemological boundaries they place on experience. Not surprisingly such an examination would reveal that by the standards of his father, his London-based church, and the church in his native country he is culturally congruent; for all believe that God can talk to you, order you to do things, talk through you (talking in tongues), and even control you.

Summary

The psychiatric commitment to an empiricist/positivist approach to unusual experiences involves a redescription of those experiences in secular/biomedical terms. This redescription may not meet the approval of the patient, especially if those experiences are apprehended in a religious framework. Furthermore, in attending to unusual experiences in a biomedical language that emphasizes 'disorder,' 'disturbance,' and so on, clinicians are—in effect—imposing the negative values associated with these terms on to the experiences, which plays a negative role in any subsequent evaluations of those experiences and contributes to the generation of harm. A closely related problem pertains to the prioritization of materialist values embedded in the DSM-IV's functional assessment over values associated with religious accomplishment. This has the effect of narrowing down the scope of function to a number of factors related to material accomplishment, allowing clinicians to declare the presence of 'social and occupational dysfunction' in neglect to other areas of functioning that are valued by the patient.

Finally, and as I attempted to demonstrate in the previous subsection, once we unpack the cultural congruence criterion, it no longer does the work it is supposed to do, which is to separate normal from abnormal beliefs and experiences by appeal to the subject's cultural group. The manner the cultural congruence criterion is applied, however, obscures this fundamental point. If the three problems discussed—broad-brush cultural categorizations, unexamined commitments of cultural peers, and a tendency to accept absence of validation as sufficient for judging 'abnormality'—are not attended to, absence of cultural congruence is hastily declared. This adds to the clinical conviction that the patient is 'ill,' thus promoting further invalidation and justifying inappropriate hospital treatment, factors—as indicated earlier—implicated in the generation of harm.

'The Danger of Words'

So far, I have attempted to demonstrate the problems with the diagnostic process, specifically how the assumptions and procedures of this process are, in certain cases, directly implicated in the generation of harm. How can we get out of this conflict? I propose that a way out is to engage the patient in an open-ended process of communication conducted with the purpose of achieving a degree of linguistic resonance among the involved parties. This would include—but would not be limited to—agreement on some form of explanatory and meaning-giving framework. But for this to work we require a conceptual shift to the effect of assessing a verbal report of an experience not in terms of its representational truth but in terms of how well it resonates with other parties involved in the process and, more generally, with society.

A Deeply Embedded Epistemological Disagreement

The psychiatrist and social worker who did the mental health act assessment on Femi simply did not believe him. There was no question of God really talking to him despite his sincerity and conviction in asserting so. His experiences constitute an 'epistemological fault' and cannot yield knowledge about the world. The DSM-IV and indeed the whole of psychiatric theory are riddled with certain epistemological assumptions. As Sadler (2005) emphasizes, Western biomedicine and its offshoot psychiatry "put(s) a high valence on truth" where research is "based on the idea that the truths of how the world works are found through the formulation of hypotheses that are tested through *experience* and observation" (273–274; emphasis added). It obviously matters what kind of experiences are to count as valid.

The scientific (and psychiatric) worldview is, roughly, of a mind-independent reality; our task is to represent it as accurately as possible. Truth within this reality would be of a correspondence type; we would have true knowledge about the world if we are able to represent reality faithfully and accurately. The project of epistemology then is to pinpoint and defend certain privileged representations (Rorty 1980).[6] Candidates for these representations have been, traditionally, basic sense experience and conceptual/analytic truths. The logical-positivists of the Vienna Circle endorsed such a position (McGrath 1998). They proposed that only two types of statements are meaningful: those that can be verified by experience and observation, and those that are true by virtue of their meaning (analytic statements). With these two kinds of 'privileged representations,' we can derive a complete picture of the world. Psychotic experiences cannot, therefore, be characterized as states of 'knowing'; they violate the accepted routes of epistemic access.

This view of epistemology—and with it our understanding of what a verbal report of an experience means—has been challenged over the past few decades. In *Philosophy and the Mirror of Nature*, Richard Rorty (1980) traces the challenge to traditional epistemology back to Sellars (1956/1997), Quine (1953/1980), and Wittgenstein (1953/1996). According to Rorty, both Sellars and Quine reach the same conclusion—that knowledge is inseparable from the social practice of justifying our beliefs to other fellow humans and is not a matter of 'accuracy of representation.' They do so, however, by attacking different strands of the logical-positivists' position.

Sellars attacked the idea that there is a basic given in experience, a given that is then articulated

and described. Launching his attack at sense-data empiricism he argued that the senses do not 'give' us facts; rather, knowledge presupposes the prior existence of concepts and learning. In this view, epistemic discourse is irreducibly normative (Rosenberg 2006). He wrote:

> In characterizing an episode or state as that of knowing, we are not giving an empirical description of that episode or state; we are placing it in the logical space of reasons, of justifying and being able to justify what one says. (Sellars 1956/1997, sec. 36)

Quine attacked the notion of analyticity, that there are statements true by virtue of meaning alone.[7] The claim that no statements are immune from revision implies that analytic statements cease to be 'privileged representations.' Together, the work of Sellars and Quine brought down the logical-positivists faith in sense-data empiricism and analyticity. Wittgenstein (1953/1996) was able to illuminate our understanding of what a verbal report of an experience means and how that relates to knowledge after the idea of knowledge as 'accuracy of representation' is discarded.[8] Here we have the idea of knowledge as truths grounded in certain linguistic practices. When we report an experience we are giving a description of it—an interpretation—that stands or falls according to how well it resonates with the wider community we exist in and not on the basis of how well it represents some independent reality (whether internal or external) accurately. These observations have decisive implications on how we view psychotic experience.

Psychosis, Community, and Choice of Language

If we assess a psychotic experience by attending to the language it is expressed in and not limiting ourselves to whether it corresponds to an independent reality (through privileged epistemological routes), we can begin to uncover the sources of conflict—and agreement—between the person having those experiences and their community, including the psychiatric authority. It has been long recognized that subjects undergoing psychotic experiences are engaged in an active process of 'meaning-finding' as a way of making sense of disturbing sensations and experiences (Kleinman 1980; Lindow 1986; Larsen 2004). This amounts to the subject creating a narrative that can accommodate those experiences, preferably in terms that are consistent with her personal biography. Biomedical language is only one possible language in this process.

A subject can talk about her psychotic experiences in biomedical terms, invoking notions of 'neurochemical imbalance' and 'brain disturbances.' She can adopt psychological language using terms such as 'conflict,' 'ego strength,' 'compensation,' or 'coping strategies.' But she can also invoke religious, spiritual, or existential language in making sense of her experiences. What language is chosen depends on the available resources in that individual's life, resources drawn from the wider cultural and subcultural repertoire. As Larsen (2004) says, the choice of explanation (language) will depend on the subject's "social positioning: influences from institutions, public media and social networks" (p. 465).

The degree of 'linguistic resonance' the subject encounters with the wider culture determines to a large extent how her choice of language will be received, whether it will be validated, and therefore whether it will serve the dual function of explaining her experiences within a coherent narrative while allowing her to find acceptance in the community she exists in. Of course, different people have different degrees of flexibility in negotiating and renegotiating the language they use to talk about their experiences. An explanation that is dogmatically held to despite finding no resonance in the individual's culture may very well be considered delusional (Larsen 2004).

Here, we have the possibility that *any* explanation can be 'delusional' in the sense outlined if it finds no resonance in the cultural group and is dogmatically held to. I recall a patient who insisted that all his problems are a consequence of 'neurochemical imbalance' despite the professional opinion that his problems are better explained and dealt with in a psychological framework. Yet a psychotic patient who adopts biomedical language is usually considered to have insight and his hallucinations become 'pseudo-hallucinations.' Similarly, in a religious context, it is at least a pos-

sibility that using biomedical language to account for the experience of 'hearing the voice of God' will be highly unacceptable as a replacement for religious language.

Communication, Linguistic Resonance, and the Fate of Diagnosis

Let us return to the case of Femi. The language he used to talk about his experiences found resonance only with the church he was in contact with in his native country. The psychiatric team deemed his explanations false. The focus in treatment was partly to enable him to gain 'Primary Insight,' which amounts to a convergence of the inferences he drew from his experiences to match those of the professionals' opinions.[9] That meant that he had to forego the explanation that God had spoken to him and adopt instead a biomedical language that emphasizes disturbance, disorder, and pathology. But why—left to his own devices and not forced to change—would he swap from a religious to a nonreligious (here biomedical) language if there are no practical advantages to be gained? In other words, he must have a motivation to change and that cannot be brought about (although the change itself can of course be) through involuntary hospitalization and forced treatment.

My proposal, then, hinges on the possibility of an open-ended process of communication, a process that involves all the parties that have a stake in the problem: typically that would include the patient, members of the influential social circle (family, religious figures, etc.), and mental health professionals, the latter—considering the current institutional arrangements—playing a crucial mediating role. The moment of contact between these parties would not be motivated by a quest for the truth, the truth in an empiricist/positivist sense, but would be a striving toward some common ground that would unite the mental health professional and the patient and, importantly, a ground that unites the patient with the society they exist in. To achieve this, we need first to realize that part of the crisis lies in the fact that different languages and their associated values are adopted by the involved parties to attend to the problem. A way out of this crisis is for all parties to engage in a process of communication that involves an attempt to modify the language they use to talk about the problem. It would not do, for example, to insist that regardless of what the patient asserts, the voice she hears is a hallucination, a symptom of a psychotic disorder; instead, we need to adopt the patient's own language, and frame the problem in terms that would meet her approval. This would inevitably involve some sort of agreement on 'what is going on,' on a meaning-giving and explanatory framework, the whole process thus placing us in a much more productive position both in terms of agreeing on a course of noncoercive, respectful intervention and in working with the patient in finding out why the language she adopts to talk about her experiences does not meet the approval of others.[10]

What place does diagnosis have in such a process? Within the advanced perspective, diagnosis is a linguistic practice parallel with all others. As such, whether or not to adopt a nosological/medical framework is a question that can only be answered in the context of an open-ended process of communication. If this process leads to agreement on a religious framework then we can begin to think of pastoral care and so on, if it leads to a biomedical framework, then imparting a diagnosis and hospital psychiatry may be appropriate; if it leads to a psychological framework, then a psychological formulation and a therapeutic context may be required, and so on.

It remains a pressing reality, however, that regardless of where conceptual work takes us we remain confronted by existing institutions and problems that require urgent intervention, usually through the available institutions. In our society, the main one happens to be psychiatry. I have argued that diagnosis should not be the main priority in every case, and that it should only be adopted—as I discussed above—if an open-ended process of communication leads to agreement on a nosological/medical framework. That being said, and as I just mentioned, psychiatry happens to be the main port of call for psychologically distressed individuals, as such it may be wiser—so long as the current institutional arrangements remain—not to abandon diagnosis all together but to use the existing nosological framework to secure the kind of help and support the patient needs. In the case

of Femi, for example, and after agreement that a religious framework is the most appropriate for his problems, a DSM-IV (APA 1994) diagnosis of V62.89 (religious or spiritual problem) could be provided only to facilitate a combined hospital/church input and support. What we should avoid, however, is the imposition of a diagnostic category regardless of all other considerations. The hope remains for a plurality of institutions, with psychiatry having no privileged position in relation to religious, psychological, and other avenues of care. That may alleviate the need for diagnosis altogether (in those cases where a nosological/medical framework is deemed inappropriate), especially if care could be arranged through alternative means without the requirement of a legitimating diagnosis.

Communication, Linguistic Resonance, and Risk

In the preceding account I have been assuming that an open-ended process of communication will inevitably lead to some form of agreement. We know, of course, that that may not always be the case. What are we to do if, despite best intentions and open negotiations, linguistic resonance cannot be achieved, complete agreement cannot be secured, and conflicts of values persist? The most obvious and extreme cases are patients intent on killing themselves, are engaged in a course of action that will lead to that, or if they are intent on hurting someone else.

Essentially, then, the question is: if my proposal is adopted, what are we to do with risk? Typically, involuntary hospitalization under section '2' of the mental health act is brought about if a patient qualifies for a 'mental disorder of a nature or degree that warrants detention' in addition to actual or perceived risk to self or others. Earlier (p. 189) I made the point that harm to others is not my concern, that being harm to self experienced as suffering, incapacity, or in extreme cases threats to physical integrity or survival. In any case we still can—with relative ease—get 'risk to others' out of the way. To do so we could argue, along with others, that protection of the public is a legal and police matter that psychiatrists could do well to take a back seat in implementing—if only to suppress claims of the use of psychiatry as a tool for social control—or, at least, to implement it knowing in advance that imposing a diagnosis to justify incarceration may lie contrary to the patients' best interests (see, for example, Bolton [2008, 233–237]).

In the case of actual or perceived risk to self, specifically risk of serious self-neglect, risk of completed suicide, and risk of fatal self-harm, there are different matters to consider. The question here is: if we accept my proposal, at what point would involuntary hospitalization be recommended in such cases? To narrow it down, we need to consider two scenarios, assuming that in all of them an open-ended process of communication was allowed to occur, linguistic resonance attempted, and the values of all the involved parties have been laid bare. The first possibility is that this process has led to partial agreement on what to do. It might be the case (think of an alternative to the manner the case of Femi was handled) that the involved parties agree the problem should be managed in a religious framework in which case threats to self posed by excessive fasting or self-neglect would be handled; in other words, we enlist the help of a suitable and agreed upon authority. The second possibility is when the process fails; despite best intentions and open negotiations, linguistic resonance cannot be achieved and conflicts of values persist (think of a psychotic patient with command hallucinations telling her to kill herself). In such a situation, I am unable to think of a 'way out' that would not involve an appeal to some independent ground to decide what to do (see Jackson and Fulford [1997, 57]). This may involve an appeal—on absolute moral grounds—that we should not allow a person to kill herself, coupled with an appreciation that that person would not have attempted to do so had it not been for intrusive and possibly temporary hallucinations.

In principle, then, the proposed approach can be adopted and carried through, knowing that in certain instances and despite all attempts agreement may not be reached. What to do when that happens is a difficult but separate question.

Conclusion

The assumptions and procedures of the diagnostic process in psychiatry are—in certain cases—implicated in the generation of harm. Moreover, this seems to be due to problems embedded in the process itself rather than the incompetence of one clinician or another. If we reformulate the clinical encounter as, essentially, a meeting of divergent linguistic practices we place the encounter on an important first step: a quest for agreement. It may seem that accepting the proposed approach would render the important vocation of helping the distressed vulnerable to an 'anything goes' relativism. As I see it, however, the moment of contact between mental health professionals, patients and other involved parties is not a quest for the truth; it is an attempt to transcend any form of explanatory, value-imposing framework—be it biomedical, psychological, etc.—that neglects the subject's personal values, for a framework that—as far as possible—secures the agreement of all. This must be the minimum standard for the generation of noncoercive and respectful intervention, and is therefore what we should aim for. Theoretical endeavors—attempts to explain psychotic phenomena in biological or psychological terms for example—are of course important, but they are important in so far as securing agreement on some such account provides ground for intervention that meets the approval of the patient.

Finally, from the perspective charted in this paper, there is no difference between a religious experience (with psychotic phenomenology) and other psychotic experiences over and above the language used to talk about the experience. An appreciation of the 'danger of words' would show that to be a significant difference, after all a simple change from religious to biomedical language can change the whole future of a person. Whether adopting a religious outlook will lead to a benign or malign outcome for those undergoing experiences with psychotic phenomenology cannot be established before hand, and indeed is not wholly determined by the clinical encounter. But to avoid transforming this encounter into one of the factors implicated in the generation of malign outcomes, clinicians need to engage the patient in an open-ended process of communication and to forego one-sided judgment.

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Notes

1. When we speak of reduction of agency in this context, we are referring to certain mental states—inner speech and thoughts—that lack the sense of being internally generated or willed by the subject. If we think about 'voices' in this way, we could meet the objections of certain thinkers who might argue that we are ignoring the possibility that God might be *really* talking to the person. I choose to remain agnostic about such a possibility and to attend instead to the phenomena conceived off in a naturalistic way, that is, as inner speech and thoughts that lack the usual sense of agency and therefore come to be experienced as external. That being said, I do not see a contradiction between a phenomenon involving reduction in agency while being valued in certain religious traditions. In other words I use 'reduction in agency' in a nonevaluative sense, as a way of describing an essential aspect of a certain experience. The fact that certain religious traditions encourage a relinquishing of personal agency to a higher power is consistent with thinking of certain states as involving reduction in agency. (See Dein and Littlewood [2007] for a similar point).

2. I maintain that, by definition, his experiences involve incapacity. However, there is no 'harm' at this stage, where harm is defined as a 'negatively evaluated experience of incapacity.' Harm depends on how he evaluates his experiences and the point is that this evaluation is inextricably bound to how others respond. Hence, the crucial importance of attending to the values of all the involved parties—including the psychiatric authority—and to the procedures of the diagnostic process before making any final decisions as to the origin of harm.

3. Two aspects of values are relevant for the purposes of this paper: values describe a quality of something, they determine a thing's worth and they function to guide and influence peoples actions (Sadler 2005). Values can be intrinsic, in which case we value a thing in and off itself, or extrinsic in which case we value a thing because of the desirable consequences it brings (Ibid.).

4. Indeed had the context been different, he might have been hailed as a spiritual figure. See, for example, Littlewood and Lispsedge (2004) and Littlewood (1997) for a discussion of some factors that may transform psychopathology [in the medical sense] to religious innovation.

5. Proudfoot (1985) takes as a starting point for his position the ideas of Immanuel Kant in his *Critique of Practical Reason* (1956). Kant demonstrated that the mind is active in experience and that objects of our

experience cannot be grasped in themselves but only through the "forms of sense and the categories that structure the judgments we make" (Proudfoot 1985, 3). Kant's position with regards to metaphysical speculation is well known: whereas experience is shaped by the forms of sense and categories of judgment, these forms and categories cannot yield knowledge that transcends our experience. In that sense, certain concepts (God, for example) refer to objects that we can not have any knowledge about. But although that might be the case, these concepts are still fundamental in constituting certain experiences. Religious concepts and beliefs, as Proudfoot maintains, are formative; they shape emotions and experiences.

6. The idea of 'Man' as an 'epistemological subject' has occupied the foreground in philosophy since Descartes. Here we have a human being conceived as "an intellect that registers sense-data, makes propositions, reasons, and seeks the certainty of intellectual knowledge" (Barrett 1962/1990, 276).

7. According to the logical-positivists, the truth of analytic statements is guaranteed a priori, because the meaning of such statements is fixed by the conventions of language. Quine was able to show that no statement is immune from revision; hence no statement is purely analytic. A statement such as, "A straight line is the shortest distance between two points" would seem to be true by virtue of meaning. But that only holds in a Euclidean world; with the advent of the theory of relativity we have come to learn of the curvature of space/time; hence, the statement above is actually false.

8. Wittgenstein's beetle is especially illuminating here:

> Suppose everyone had a box with something in it: we call it a 'beetle.' No one can look into anyone else's box, and everyone says he knows what a beetle is only by looking at his beetle. Here it would be quite possible for everyone to have something different in his box. One might even imagine such a thing constantly changing. But suppose the word 'beetle' had a use in these people's language? If so it would not be used as the name of a thing. The thing in the box has no place in the language-game at all; not even as a something: for the box might even be empty. (Wittgenstein 1953/1996, sec. 293).

In reporting a beetle (or a headache) we are referring to "whatever is in the box," which might very well be completely different from what is in other people's boxes. But the purpose of the word 'beetle' (or headache) is not to refer to an identical object (or brain state) that I and other people have but to refer to whatever is in the box (i.e. to an introspectively reportable change in the nervous system) and that might widely differ between you and me. To extend the analogy further, we have been taught to use the word beetle under certain circumstances, its part of a 'language-game,' as such whether or not we are using the word accurately depends on a linguistic community and the inferences they permit to and from such experiences.

9. Insight is generally considered to be a multidimensional and continuous construct. It involves recognition by the patient that they are suffering from a mental illness, an ability to label unusual mental states as pathological and agreement on the attribution of proper causes to symptoms (David 1990; Amador and Strauss 1993). In practical terms, these dimensions all involve a discrepancy between the patient's opinion (concerning their mental states) and the opinions of the professionals, and it is this aspect of insight that I am referring to here as 'Primary Insight.'

10. This last point recalls the concept of 'secondary insight,' which I take as referring to the subject's ability to take an observer view of herself and to appreciate that she might have deviated from consensual opinion in what she is asserting. In working with the patient toward secondary insight, we develop, with the patient, an understanding of why other people (the relevant [sub] cultural group) might find her experiences and the language she uses to talk about them unusual or bizarre.

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