CLINICAL PSYCHIATRY, PSYCHOPHARMACOLOGY, AND ANOMALOUS EXPERIENCE

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The history of psychiatry is riddled with attempts at unifying psychiatric diagnosis. More than a hundred years ago (1860), psychosis was summarized very simply by Heinrich Neumann: "There's only one kind of madness, and we call it insanity" (Neppe, 1982c). Over the next fifty years, this broad conceptualization was insufficient. Instead, numerous labels were placed onto mentally ill patients, such that psychiatric diagnosis was at its most varied and most scientifically inappropriate.

What has historically been perceived as a major breakthrough in psychiatry occurred in the 1890's: Emil Kraepelin's discovery of the term Dementia Praecox (Kraepelin, 1899). This condition was renamed schizophrenia in 1911 by Eugen Bleuler. Bleuler (1911) emphasized specific symptoms occurring at specific times, and the conceptualization of a split between cognitive and emotional functions. This differed from Kraepelin's conceptualization of a deteriorating illness occurring over many years, presenting in the young, and, ultimately, exhibiting features of intellectual deficit. These two conceptualizations of schizophrenic illness reflect prevailing philosophies pertaining to the importance of cross-sectional symptoms (i.e. symptoms occurring at a specific moment in time) and longitudinal features (i.e. symptoms occurring over periods of many years reflecting the course of illness). It was with this conceptualization in mind that Kraepelin (1922) subdivided major psychiatric illness into three, namely: dementia praecox, manic depressive insanity, and epileptic insanity.

It is worthwhile reflecting that our current classifications of psychosis are even more limited than this, and emphasize two major conditions: schizophrenia and affective (or mood) disorder (either bipolar illness or unipolar major depression). From these two major conditions arises a variety of others: for example, in between is so-called "schizoaffective disorder"; when there is suspicion of organic impairment, we talk of "organic delusional syndrome" or "organic hallucinosis"; and inability

to classify these conditions under any of these broader headings results in the diagnosis of "atypical psychosis". Even worse, this term "atypical psychosis" no longer exists in the Diagnostic and Statistical Manual, (Third Edition, Revision) of the American Psychiatric Association, the bible of psychiatric diagnosis, and has been replaced by "psychosis, not otherwise specified" (American Psychiatric Association Committee, 1987). A large proportion of our current psychiatric diagnoses do not fit well into any of these Procrustean frameworks, where specific clinical criteria have been worked out, and where patients are expected to be placed within diagnostic categories which may have dubious clinical relevance. Psychiatric diagnoses today are at times a dumping ground for the diagnostically destitute.

This cynical viewpoint is based, unfortunately, on empirical experience. Some 15 years ago it was said that the easiest way to cure schizophrenia was to travel across the Atlantic. This reflected the diverging views of this condition in American and European psychiatry. (See Neppe, 1982c). Fortunately, criteria unification at the clinical level has led to more consistent diagnostic labels. But these are only very relative, and every week my colleagues and I see patients who have a prolonged psychiatric history with a variety of different previous diagnostic labels. First admission, borderline personality disorder; second admission, schizoaffective illness; third, schizophrenia; fourth, mania; fifth, atypical psychosis; sixth, maybe one of these earlier conditions, maybe organic delusional disorder. Clearly diagnostic nomenclature at this point in time, from the psychosis framework, is in difficulties, and the same applies to the more limited neurotic kinds of illness.

This emphasis on the deficiencies of current psychiatric nomenclature is made for another reason. When groups of symptoms such as anomalous experiences, or experiences which are out of the ken, the training, the knowledge base, and the conventional framework of clinical psychiatry appear, these features are perceived frequently as psychopathologic, and attempts are made to place the experience within the frameworks of one of these broader diagnoses. Thus "out of body" experience can, at its broadest psychopathologic level, be perceived as "extreme ego splitting, with marked derealization and depersonalization, and delusional out-of-touchness with reality" (Neppe, 1982b). Precognition can be perceived as a "primary delusional idea, with alienation, passivity, or reference phenomena." The same may be said for other forms of ESP such as contemporaneous clairvoyance. Telepathy can be perceived within the framework of thought-broadcasting or thought insertion, both "first-rank symptoms", outlined by Kurt Schneider, 50 years ago (1959). Trancelike states, and writing auto-

matisms, can be perceived as extreme dissociative phenomena, or as extreme passivity phenomena within the framework of psychosis (Neppe & Smith, 1982). These symptoms may in fact be interpreted correctly under certain circumstances: Clearly patients who are psychotic may misinterpret reality, and it is not uncommon for such patients to believe themselves psychic, and to act out their delusions (Neppe & Tucker, 1989). They may well join subgroups who will accentuate such belief systems. This does not, however, imply that all subjects with subjective paranormal experience, or anomalistic experience, are psychotic, yet psychiatrists have in general attempted, without empirical studies, to insert such symptoms into the framework of psychopathology and abnormality (Neppe & Tucker, 1989; Neppe, 1984a).

What alternatives exit to this current state of affairs? We can use approaches, such as those of Robert D. Laing (1976), or Thomas Szasz (1957), and perceive the patient as not necessarily pathological. His interaction with society is damaging because of societal labeling and sociocultural misinterpretations. This, therefore, shifts diagnoses out of the framework of the psychological to the sociocultural.

An alternative is to approach diagnostic nomenclature at two levels—firstly, the functional, and secondly, the psychopharmacologic. I believe that these together form an appropriate approach. Using the functional framework, one perceives the patient in the context of his biological, psychological, social, family and cultural functioning. One perceives him as a biopsychofamiliosociocultural system (Neppe, 1989a). Defects at any of these levels producing noncoping, or non-optimal coping, can be perceived as psychopathologic. No matter how strange the patient's experiences are, they are not perceived as abnormal unless they distinctly interfere with the patient's functionality and coping skills (Neppe, 1984b). This is a good, basic, empirically-derived definition, which allows paragnosts to experience realities which others may not be able to conceive of, but which do not produce labels of psychopathology.

The second, related approach, actually fits within this first, and involves emphasizing the biologic components to psychiatric disorder (Neppe, 1989a). A great deal of research has occurred in the modern era, trying to find biological correlates for such conditions as schizophrenia and affective illness. Specific tests have attempted to differentiate these conditions —at this point, unsuccessfully.

Less emphasized, and a theme of my latest book, (Neppe, 1989a) is the marriage of psychopharmacologic responsiveness and toleration of psychotropic medication to psychiatric diagnoses. It is largely irrelevant to me whether or not a patient is necessarily labelled schizophrenic,

schizoaffective illness, organic delusional syndrome, or mood disorder. If a group of patients respond to a specific medication, or combination of medications, I believe this cluster of patients is far more homogeneously expressed by this responsiveness to specific combinations of psychotropic medication, irrespective of diagnosis (Neppe, 1983, 1989c; Neppe & Holden, 1989).

Moreover, we have a very conventional, useful, underused and underemphasized diagnostic test. It is said the "normal person would not handle such crazy medications," and this is quite true: High doses of psychotropic or antipsychotic medications are tolerated only by patients who are psychotic, have severe personality disorders, have drug dependency problems, or have an extremely active liver, (allowing very rapid breakdown), or a poorly functional gastrointestinal tract (at that point allowing nonabsorption). The average person, in the vast majority of cases, does not tolerate antipsychotic doses of neuroleptic medication (Neppe, 1989b; Neppe & Wessels, 1979). This implies that we have specific biochemical diagnostic traces that differentiate normal from psychotic conditions.

Thus, two principles exist in differentiating out normative from abnormal behavior. First, the definitions of coping at a functional level (Neppe, 1984b); and secondly, psychopharmacologic toleration and responsiveness as an underlying indicator and expression of biochemical abnormality, which produces, not only the psychopharmacologic epiphenomena, but also the epiphenomena of specific clinical symptoms (Neppe, 1983a, 1983b). Expression of such clinical features is limited by the brain to a few such experiences. The patient may experience hallucinations. He or she may experience symptoms pertaining to delusions and thought disorder or emotional changes, such as depression or euphoria. Alternatively, he or she may experience anxiety, agitation, aggression, alienation and distortion in terms of caring experience. He or she might experience differences at the psychomotor expression level, and at the motivation level. In more extreme cases, he or she may experience alterations of consciousness, insight, judgment, and overt dangerousness to him or herself or others. Finally, he or she may experience specific focal cerebrocortical features, such as apraxia or aphasia. This limitation in expression of symptoms by the brain is also appropriate with regard to subjective paranormal experience. So, for example, it is well demonstrated that out-of-body experience, or autoscopic experience, may be induced by stimulating certain areas of the temporal lobe of the brain (Neppe, 1984c; Penfield, 1958). This may be mechanistically quite different from out-of-body experience as it occurs in the paragnost. The limited expression is a final common

pathway (Neppe & Holden, 1989; Reed, 1972). Great dispute exists with regard to a second final common pathway: the commonality of the near-death experience (Neppe & Tucker, 1989). Similar comments can be made with regard to deja vu (Neppe, 1983b) and also with regard to hallucinations (Neppe, 1983a).

Hallucinations are particularly relevant because using a psychiatric model they persistently are interpreted as expressing major psychopathology, generally psychosis (Van den Berg, 1982). Yet there are normal hallucinations. Well-known, for example, are so-called hypnagogic and hypnopompic phenomena occurring in normal subjects and also in the narcoleptic, and not regarded as pathologic as such (Neppe, 1983a).

Less well-known are the surveys by Sidgwick and associates (Sidgwick, Johnson, Myers, & Sidgwick, 1894) and 50 years later by West (1962) who demonstrated, in a very large survey (Sidgwick, approximately 10,000; West, more than 1,000) of normal people, that the incidence of hallucinations, predominantly visual hallucinations, occurring at least once in a lifetime in the population, is of the order of 10–14%. These visual hallucinations cluster around a death, even when that death is unexpected and unknown. The significance of this finding is relevant, not only to parapsychological research, but to the psychiatric context of a major trauma being linked in terms of reported past memories of a strange experience, such as a visual hallucination. This, therefore, would potentially accentuate inaccurate anecdotal memories (Devereux, 1974; Ehrenwald, 1948; Greyson, 1977).

Given the small ways of expression of the brain, some of which may be subjective paranormal experiences (SPE), (Neppe, 1980a) it is important to analyze which psychiatric diagnostic groups are most likely to exhibit SPE, and whether these have been perceived as pathologic or normal. Table 1 lists the major groups dealt with.

TABLE 1

Psychiatric Conditions Most Likely Associated with Subjective Paranormal Experiences:

Group 1. Schizophrenics;
Group 2. Hallucinogenic Mobilized Psychoses;
Group 3. Subjective Paranormal Experience Psychosis;
Group 4. Trancelike Dissociative Phenomena;
Group 5. The Psychotic Psychic;
Group 6. Epilepsy and Non-Epileptic Temporal Lobe Dysfuction.

Schizophrenics

Schizophrenics and other psychiatric patients with similar psychoses, like acute exacerbations with schizoaffective illness, and patients with manic episodes, often present, with hallucinatory and delusional experiences that are very much linked to the sub-culture (Neppe & Smith, 1982). If they are religious, they may perceive themselves as Jesus, or as Judas, and may therefore want to act out, in a grandiose or persecutory manner. Those with mystical type experiences may perceive themselves as higher beings, or alternatively, may regard themselves as being extremely psychic, and having clairvoyant and telepathic abilities (Neppe & Smith, 1982; Rogo 1975).

Such symptoms are particularly relevant because they reflect the Schneiderian "first-rank symptoms" of psychosis, namely: passivity phenomena and alienation (Schneider, 1959). Alienation and passivity phenomena relate to a distortion of the patient's ego, whereby influences are received from outside producing an influence on thinking, emotions, drives, impulses or bodily functions. When not only influence occurs, but the outside influences are perceived by the patient as controlling these phenomena, the experiences at times become alien. Such features are hallmarks of psychosis, and the major component is the reference to self, with distortion of ego boundaries (Neppe, 1988a, 1988b).

Logically an extension of this distortion of self is the perception that the patient is receiving information from outside by telepathy or clairvoyance; that others are reading his mind; and that he can read others' minds; that his thoughts can be broadcast; and that there is therefore no need to communicate by speech. Patients may develop a fixed delusional system pertaining to their being psychic, or being able to predict the future. It is interesting that such patients are unable to substantiate any factual evidence, and when they do give examples, the examples are usually inconsequential, and sometimes non-sequiturs. ("I knew I would see my father, and I did, three weeks later." Or: "I knew I would see my father, and, when I did, I was aware that he was the devil.") These features therefore have links with psychosis. Very often the patient talks in vague terms or contradictory terms, and when confronted in this regard, will attempt to explain the phenomena in an even more delusional kind of framework (Neppe, 1984b; Neppe & Holden, 1989).

These patients do not cope at the biopsychofamiliosociocultural level, and they will tolerate high doses of neuroleptic agents—fulfilling the two criteria I have suggested for psychosis. Moreover, this antipsychotic

group of drugs will assist in allowing them to attain greater awareness of reality. Thus, the schizophrenia-like psychoses, and, at times, manic illness, may present with a grandiose component, looking like psychic experiences, but manifesting other groups of vegetative and cognitive symptoms, which are clearly inappropriate and associated with decompensation and impaired functioning of the patient.

Hallucinogenic Mobilized Psychoses

The second sub-group relates to patients who have had hallucinogen drugs, either during their episode acutely, or in the past. Two commonly used ones are LSD and PCP. These drugs produce a schizophrenia-like state, either acutely or in more chronic form, but with certain special differences. Very often the mystical element, in terms of mind expansiveness is particularly exaggerated, and this produces distortions in appreciation of time perception. Such distortions are common in schizophrenics, but hallucinogen-mobilized psychosis is the prototype example (Neppe, 1982c).

These patients have difficulty differentiating seconds from hours, days from minutes. Their estimate of time is very wrong. They exhibit a certain apparent mystical expansiveness, whereby they describe feelings of all-knowing, and awareness of realities that they could not even have believed were possible: these experiences may be extremely frightening, or may be associated with euphoric qualities. At times they talk of flashbacks back to such experiences. All these experiences may be reflecting their acute psychotic reality, either under the acute influence of hallucinogens, or through their presenting with a more prolonged schizophrenia like kind of illness, which seems to have initially been mobilized by hallucinogens. This condition does not have the typical negative features of schizophrenia: the withdrawal, the apathy, the autism, the out-of-touchness with reality components, and the substantial lack of insight. Instead, these patients have some insight, are aware that something is strange and that something is different. They have positive hallucination type features, but very often they have visual hallucinations as opposed to the classical, complete auditory hallucinations one sees in schizophrenia (Neppe, 1982c; 1983a).

Such cases are at times more difficult to differentiate in terms of psychic experiences because the pseudo-philosophicality and their mind expansiveness at times makes them look like geniuses or extremely intelligent people, until one listens carefully to the quality of thought, and the distortion of interpretation of reality base.

Subjective Paranormal Experience Psychosis

The third group of conditions, of importance at a clinical level, is Subjective Paranormal Experience Psychosis (SPE Psychosis) (Neppe, 1984b). This condition was originally described by myself in the early 1980s to fill a gap in the literature relating to people who gave a history of ostensibly genuine subjective paranormal experiences, starting in childhood. However, at some point in their early adulthood, they presented with acute psychotic decompensation.

The major feature that had changed—heralding the psychosis—related to self-reference ideation. Suddenly their awareness, their "psychic experiences," were not about others or about the things of little relevance to themselves; instead, they started having experiences about themselves producing enormous distress, because of the dysphoric nature of such experiences such as beliefs that they may die (Neppe & Tucker, 1989).

This condition was characterized by a cluster of features as follows:

1. onset of subjective paranormal experiences (SPEs) during childhood, often before the age of five, certainly before the age of ten;
2. history of numerous subjectively well-validated subjective paranormal experiences (SPEs) which related to others, never to themselves;
3. history of onset of a psychotic episode at any stage of one's life manifesting as self-reference "delusions" pertaining to at least one of these subjective paranormal experiences;
4. such an SPE may relate to the subject's death;
5. a phase of acute turmoil precipitated by self-referential SPEs with the conviction that the SPE is true, but turmoil because it cannot be proven;
6. a phase of very sudden recovery after the SPE has been shown to be false;
7. absence of progression with no phase of deterioration longer than six months;
8. absence of family history of major psychiatric illness;
9. presence, at times, of family history of subjective paranormal experiences;
10. or alternatively, marked antagonism within the primary family group to psi;
11. absence of response to the appropriate management of the conventional differential diagnosis which is most reasonable;
12. no previous psychiatric history;
13. maintenance of congruous and appropriate affective responses;
14. exclusion of physical causes (Neppe, 1984b).

Trancelike Experiences: Paragnosts and Hysterics

The fourth group of subjects have trancelike experiences. Again, there is a subdivision of those that are coping and functional, and apparently claim trancelike experiences as part of their mediumistic communications. These subjects, in general, have subjective paranormal experiences generally of very diverse kinds, such as out-of-body experiences, and various kinds of contemporaneous, retrocognitive and precognitive clairvoyant or telepathic type experience, either in waking reality or during dreams. They may or may not claim psychokinetic experiences. Their trancelike experiences are usually associated with an alteration or defect of consciousness and they have an amnesia in general for any verbalizations that occur during this phase. This amnesia is not, however, invariable, and it is not uncommon for these subjects to exhibit a dual consciousness. The quality of verbalization or vocalization may vary both in kind of voice (i.e., own or other) and in degree of veridical information (Neppe, 1982b; Neppe & Smith, 1982).

As opposed to this "normal" sub-group is a second group of patients who have hysterical dissociative episodes whereby they assume a different form of identity or behavior and exhibit amnesic components. This generally follows on a major stress in their life, and has an acute onset and relatively acute offset. At a later point in time there may be patchy memories, and generally these episodes can be recreated in such altered states of consciousness as hypnosis. The core component of such conditions relates to the appropriateness of the psychodynamics (Neppe & Smith, 1982).

The problem with the two subgroups of these conditions is that it is possible the subject may exhibit trance kinds of experiences, and also hysterically dissociate. In any event, clearly any vocalizations obtained during so-called psychic trance experiences may well be contaminated by underlying psychodynamics and emotional state of the subject (Devereux, 1974).

The Psychotic Psychic

The fifth group is similar to the first, the group of patients with subjective paranormal experience psychosis. But in this instance, it is approached from the other end. Patients who are psychotic or exhibit other forms of what is perceived as special, bizarre pathology, such as seizure disorders, are accepted within the subculture, or within their preliterate culture, as having special mystical abilities. They are trained to become indigenous healers, witch-doctors, sangomas, or shamans (Neppe & Smith, 1982).

This subgroup of patients is biochemically distinct because they exhibit toleration of high doses of antipsychotic agents, and need control of their symptoms with psychotropic medication. Alternatively, their mystical behavior—seizures—responds to anticonvulsants (Neppe & Smith, 1982).

Non-epileptic Temporal Lobe Dysfunction and Temporal Lobe Epilepsy

There is an important, sixth group of patients with non-epileptic temporal lobe dysfunction and with temporal lobe epilepsy who may hypothetically manifest subjective paranormal experiences. This hypothesis is based on the reverse research, whereby I demonstrated, in the early 1980s, that there is a very substantially increased incidence of possible temporal lobe symptoms in subjective paranormal experients (Nelson, 1980; Neppe, 1980b, 1983c, 1984c). These are subjects who claim a large a number of SPEs of at least 4 different kinds, and these SPEs have been subjectively validated on at least 16 occasions. They form the tip of the iceberg of apparent substantial paragnosts. Without exception they manifested temporal lobe symptomatology, both relating to their SPEs (i.e., a state phenomenon), and also, independent of their SPEs (i.e., a trait phenomenon) (Neppe, 1983c). This suggested that an anomalous pattern of temporal lobe functioning may allow them to experience an exogenous or endogenous reality, which most people are unable to experience (Neppe, 1984c).

It is interesting that the "normal" subjective paranormal experients, however, exhibit possible temporal lobe symptoms of qualitatively different or unusual kinds. They experience, for example, pleasant, perfumy, or flowery olfactory hallucinations, (Neppe, 1983) in addition to experiencing, at times, the more common olfactory hallucination of temporal lobe epilepsy, namely, unpleasant, burning, or rotting smells (Neppe, 1981a, 1983). In addition, these patients do not experience temporal lobe epileptic type deja vu, but subjective paranormal experience deja vu (Neppe, 1983b). These point to qualitative differences that may still localize the area of integration of SPE to the temporal lobe, which, in addition, for theoretical reasons, would be a good choice (Neppe, 1981a, 1981b, 1982a, 1984c).

Consequently, I set out to establish whether or not the reverse was true. Do patients with non-epileptic temporal lobe dysfunction, or patients with temporal lobe epilepsy, have more subjective paranormal experiences? Unfortunately, this research is not easy. Firstly, the great majority of the population, generally 70–90%, in numerous surveys in

different countries, claim at least one subjective paranormal experience in their lives, with the consequence that the occurrence of SPEs in this population is of no great significance (Neppe, 1981c; Swiel & Neppe, 1986). What may be more relevant is the occurrence of *frequent* SPEs. This is common ground in patients with temporal lobe dysfunction and temporal lobe epilepsy.

It is interesting that, in my experience, when these patients are placed onto anticonvulsant medication, such as carbamazepine (tegretol), they invariably improve, in terms of their temporal lobe symptomatology, and this improvement parallels the diminution or non-occurrence of subjective paranormal experiences, as well as a diminution in creativity, in musical ability, and ability to write poetry. Results at this point relate to my open studies and my pilot experience with these patients involving careful evaluations. The numbers are extremely low, in that the majority of patients with temporal lobe epilepsy do not want to talk about their SPE symptoms lest they are labelled as uncontrolled. There are numerous constrictions and restrictions to such discussions because of the medical and legal implications of operating machinery and driving vehicles for patients who are still seizing. This appears to be an extremely promising direction of research, however. It is interesting that we have described a family with coexistent temporal lobe dysfunction and subjective paranormal experiences (Hurst & Neppe, 1981, 1982). It appears that a family history of epilepsy is a common phenomenon amongst paragnosts. Again, this is fraught with diagnostic difficulties because the patient with epilepsy is seldom available for further investigation. There are anecdotal components to this.

Perspective

This paper has attempted to evaluate psi in the clinical psychiatric context. Clearly the phenomenon occurs. At times the description appears to have psychotic elements. There is always a psychodynamic flavoring to experiences of various kinds, but the essence of pathology appears best based on the biopsychofamiliosociocultural model of the patient not coping, and the patient being able to tolerate, and respond to, appropriate psychotropic medication, particularly neuroleptic medication or anticonvulsants, such that this may implicate underlying biochemical traces.

It appears that the area of the brain most involved is the temporolimbic system. However, clearly psychodynamics are of enormous relevance in any psychotherapeutic relationship, and attempts at explain-

ing phenomena may involve psychodynamic explanations, even in the organic patient.

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DISCUSSION

HARARY: Isn't it possible that psi is also sometimes a positive response to other things and is in itself part of coping in a positive manner to other events? Also, the use of the term psychics, I assume you're using that term loosely since we don't really know what those are yet. And, can a person be diagnosed as psychotic and still be experiencing legitimate psi?

NEPPE: You have already answered the first two. The third one, I don't know. Bruce Greyson tried to address the question of psychosis

but overall it hasn't been well addressed at all. It is very difficult because psi is such an elusive phenomenon and objective tests in a lab are probably not best done on people who can't concentrate anyway. I think this is the essence of it all. One does very often see escape phenomena. I will just throw around an interesting one. I remember one of my colleagues at a local mental hospital, a male psychiatrist round about 50, whose patient had an episode of crying and was most distressed, going on for days. She kept insisting that he had died. We kept saying, "But he hasn't died, here he is." We brought him along and this relieved her a little, but she was still distressed. A few months later, he died suddenly after not being ill. The exact time relationships are unclear as it only occurred to me some years later that this kind of event could conceivably happen. I started saying to myself, "Hold on. These kinds of events do seem to happen in a psychotic related context as well. Is there a coincidence component? Is there any subjective or objective validation?" Unless one does rigid scientific research, recording predictions of any kind, irrespective of how bizarre they really seem to be, I don't think one can have the answer.

VON LUCADOU: I think it is very important to realize that real psi phenomena are elusive, and the phenomena which are reported by psychotic persons are not elusive. They always say that they have these feelings. I think this is a good discriminator for detecting real psi events and non-real psi events.

NEPPE: Excellent point.

MCHARG: I think I enjoyed the talk as much as Vernon Neppe did himself. I wanted to make one point about known psychics and a psychotic patient who I've mentioned before, a young schizophrenic who I was interviewing for the very first time. He'd never met me before, and this was the time when I had been preoccupied with Jungian synchronicity, but this didn't come into the interview at all. On pressing him as to how he felt that his illness had begun, he said that it had started when he was aged five, and his father and mother were having an argument about Jung's concept of synchronicity. It so happened that his parents had in fact separated at that time. Many years later I had the opportunity of meeting his father and raising this question with him. The father made it quite clear that he had never heard of Jung. This is just an example of what surely was a paranormal phenomenon in the case of the schizophrenic patient.

BENOR: Unfortunately patients don't come to these conferences and don't tend to conform to the categories that we set up. Often times they like to tease us by sitting between them and demonstrating phenomena that cross the boundaries. In South America they teach healers

and mediums to control their epilepsy as a way of entering into mediumship and it may be that we have something to learn from them.

NEPPE: That's a very interesting point. What incidentally is relevant in that context, and also in the context of the potential link between epilepsy and psi experience, is the fact that one so commonly finds family loadings of epileptics in people with subjective paranormal experiences. I was in Oregon a month or so ago speaking to somebody who was in charge of watching out for bush fires from a little cabin at the top of a mountain. He explained to me that it becomes very frightening when the lightening strikes. He has a particular place to stand which has special kinds of conductors to avoid him being killed by the lightning which sometimes strikes his cabin. He said, "It makes one fully aware. I'm fully able to see all the way through into the future." I said to him, "Really." I got very excited and asked, "Does that happen often?" He then told me about a couple of instances of precognition. I said to him, "Tell me about the smells you get." He said, "I get these pleasant perfumey smells." I thought I was on the right track so I said, "Who in your family has epilepsy?" He said, "My mother's epileptic." I said, "All right, thank you." So, there is this link up, and it's not a small link up. It's a major link up.

LANG: I want to ask you a personal question about working with the police and smelling some odors that were documented around the death of an individual. Are you saying to me that a normal person can have these kinds of experiences without temporal lobe dysfunction?

NEPPE: Yes. I have used the expression anomalous temporal lobe functioning because you can base the interpretation on different kinds of temporal lobe functioning. In other words, there is a different way of appreciating reality from the ordinary person. I don't think you ought to use the phrase normal-abnormal in that context because all my subjective paranormal experience population were eminently normal, but they all had these features. The fact is, that if one has these features and one has a seizure disorder, then why not treat the seizure disorder? If one was psychotic one would treat the psychosis. But people have these experiences and they're quite normal, and there has to be an area of the brain that allows them to integrate or appreciate these experiences which do not necessarily come from outside. They may originate within the brain: my area of research at a subjective level does not allow appreciation of origins. I look at subjects as opposed to the experiences, and try to link them up in terms of appropriate patterns of brain functioning.

KRAMER: Last year in Holland, there were two conferences where clients and psychiatrists came together to discuss the topic of hearing

voices in their heads. It turned out that it was very, very good, especially since the clients and the psychiatrists were able to give addresses about the topic and talk to each other on the same level. It turned out that both the clients and the psychiatrists learned a lot from each other. It has been a tremendous success. Actually, they did it twice because one conference was not enough to cover all the topics they had to talk about.

NEPPE: Just to corroborate that, most of what I have learned about psychopathology, I've learned from my patients.

WICKRAM: We know that hallucinations can be generated by psychopathological crisis, by drugs and unusual sensory stimulation. But DSM-III seems to pay no attention to the fact that if you walk into a room of people who are non-psychotic, nearly 10% of those people, "normal" people, can hallucinate in some sensory modalities. They can do this but the difference between these people and the psychotics is that they can turn their hallucination on and off. They have voluntary control of the hallucinatory process. DSM-III, as far as I can see, pays no attention to that.

NEPPE: Certainly one doesn't find recognized by the American Psychiatric Association in general, the perception of hallucinations as normal phenomena because one tends to see patients with pathology. I don't think patients with normal spontaneous hallucinatory experiences have ever been reported to be able to turn them on or off. In the great majority of instances, the hallucinations have tended to be of visual kind, and tended to have been very rare as phenomena. I think the point that you are making, which is a good one, is the fact that these kinds of experiences occur in the context of people that are coping, that are functioning, and where the hallucinations do not intrude to any marked degree into psychopathology.

WICKRAM: The dimension of coping is critical. The dimension of control is critical. If you can't control, you feel out of control and then you think you're crazy.

NEPPE: The control context you are using there is the control in terms of response.

WICKRAM: Yes, self-control of the material.

VAN DE CASTLE: I'd like to acknowledge that Dr. Neppe has said he has learned about psychopathology from patients. I would like to ask Dr. Neppe where has he learned about psi?

NEPPE: To a large degree, from psychics, exactly the same kind of source.

HARARY: What are they?

NEPPE: Alright, from subjective paranormal experients.

TIERNEY: DSM-III-R makes the distinction between ideas of reference and it excludes delusions of reference. I have never been clear of what the distinction is. Could somebody tell me?

NEPPE: When one speaks of delusions, one is speaking of fixed false beliefs which are inappropriate within the framework of the socioculture of the subject. When one talks of ideas of reference, these may not be inappropriate fixed false beliefs. They may just be the interpretation of something as having a critical relevance to oneself. One common idea of reference which is not delusional is the idea that "maybe they were whispering, I'm sure they were whispering about me." This certainly would not be interpreted as psychotic in the delusional sense. Delusions, by definition, have a psychotic framework to them.

TIERNEY: Do you think it is clinically significant enough to include a differentiation?

NEPPE: Yes. I think the differentiation is clinically significant from the point of view of schizotypal personality disorder, because if one was talking about delusions per se, one would have to say these people have an underlying psychosis. If they had an underlying psychosis, it would be difficult to say they have an underlying personality disorder. Now, of course, we've got to look historically at the schizotypal personality as previously having been called simple schizophrenia. So, we are very much dealing with an interface area.

WEST: I think the basic thing here is the distinction between the phenomena that one sees in people who appear well and those who are very obviously ill. The phenomena in the sick have, apparently, a physiological basis in the majority of cases. Some of them are due to hallucinogenic drugs, some of them are due to drugs which have a toxic effect, some of them are due to the alteration of the biochemistry of the brain which can be shown by their reaction to psychotropic drugs, and so forth. For those phenomena, we seem to have a kind of physical explanation. For the spontaneous psychic experiences that occur sporadically to people in apparently perfectly normal states who are functioning perfectly well in the community, I think we have no explanation, whatever. I think it is necessary to try to explore, not only the hallucinations which are veridical, in the sense that people can attach the content to some particular stimulus, but also those which are not. There are various theories that go around in psychical research which have not been mentioned here, such as they are ghosts, they are spirits of the dead, they are people from another planet, all sorts of things. But really, we just don't know and we ought to find out more.

MEYER: Following up on what Dr. West just said, there seems to be

some room in your taxonomy, I think, specifically in the SPE area for people who are normal functioning and have sudden shifts in paranormal experiences. I'm thinking specifically of Grof's work and wondered if you had taken that into consideration?

NEPPE: Yes, I think it's very important, and I think the context of shifts in terms of altered states of consciousness and in terms of psi sensitivity, has certainly been an area that has been addressed. Shifts in awareness of incidents of subjective paranormal experience seem to occur as spontaneous phenomena within individuals. Certainly, one has seen that a major problem from a laboratory point of view is that people always talk about replicating an experiment. Why cannot parapsychology produce the replicable scientific experiment if their findings are appropriate? Well, if one looks at the subjects, the experimenters, and the researchers, as the major piece of apparatus, and if one looks at the complete context of everything having to be just right, it is difficult to exactly replicate all the apparatus. These shifts, therefore, I think are very interesting phenomena because they might in a way allow just that little bubble to escape through.

PARKER: I'm going to take up in my paper aspects to do with perceptual changes and shifts, and states of consciousness. From this point of view, it's very interesting to look at the prodromal phase, the initial phase in the development of schizophrenia. A couple of studies have found that schizophrenic patients are actually sensitive to when they go into a psychotic episode. They know these certain perceptual changes. Do you know anybody who has actually studied this from the point of view of testing psi, whether psi tests have been carried out before the psychotic experience becomes full-blown?

NEPPE: No. I think that would be a very interesting area to study. I think the major limitation is the psychiatric status of the patient, and the fact that they may not be able to fully cooperate in tests requiring particular modes of attention, which may be foreign to them.

HARARY: I was just thinking about the idea of shifts of attention. If we approach psi as neutral information that is available to be observed, then aren't we talking about what it takes to get to observe it? There may be many different kinds of things that can help an individual observe that information in different ways. Also, people, who are in either various states of consciousness or various states of being in touch or out of touch with what we call reality, might observe, relate to, or be able to access that information in various ways depending upon where they are coming from initially.

NEPPE: I think that's a comment which seems very reasonable.