

The Differentiation of Psychosis and Spiritual Emergency

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STATEMENT

This work has not been previously submitted for a degree or diploma at any university. To the best of my knowledge and belief, the dissertation contains no material previously published or written by another person except where due reference is made in the dissertation itself.

Signed

..... / December 2007

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TABLE OF CONTENTS

STATEMENT	ii
ACKNOWLEDGEMENTS	iii
TABLE OF CONTENTS	iv
LIST OF FIGURES.....	vii
LIST OF TABLES	viii
ABSTRACT	ix
CHAPTER 1: INTRODUCTION.....	1
1.1 Overview of the Thesis.....	1
1.2 Objectives of the Thesis.....	3
1.3 Underlying Theoretical Perspectives.....	4
1.4 Methodology	7
1.5 Outline of the thesis	8
CHAPTER 2: PSYCHOSIS	11
2.1 Introduction to Psychosis	11
2.2 Psychosis and the DSM-IV(TR)	13
2.3 Medical Model of Psychosis.....	22
2.4 Non-Medical Models of Psychotic-like Behaviour	27
2.5 Conclusion	37
CHAPTER 3: SPIRITUAL EMERGENCY.....	40
3.1 Introduction to Spirituality.....	40
3.2 Introduction to Spiritual Emergence	47
3.3 Introduction to Spiritual Emergency	49
3.4 Introduction to the Sub-types of Spiritual Emergency	51
3.5 The Healing Potential of Spiritual Emergency.....	61
3.6 Conclusion	63
CHAPTER 4: SUB-TYPES OF SPIRITUAL EMERGENCY	65
4.1: THE DARK NIGHT OF THE SOUL.....	65
4.1.1 General Introduction	65
4.1.2 The Dark Night of the Soul.....	66
4.1.3 Models of the Dark Night of the Soul	68
4.1.4 The Dark Night of the Soul and Psychopathology	70
4.1.5 The Dark Night of the Soul as Spiritual Emergency.....	72
4.1.6 Summary	74
4.2: THE AWAKENING OF KUNDALINI.....	75
4.2.1 Introduction to Kundalini	75
4.2.2 The Kundalini Experience	76
4.2.3 The Awakening of Kundalini	79
4.2.4 Kundalini Awakening and Psychopathology	82
4.2.5 Kundalini Awakening as Spiritual Emergency.....	84
4.2.6 Summary	85

4.3:	THE SHAMANIC CRISIS	86
4.3.1	The Shamanic Experience.....	86
4.3.2	The Shamanic illness.....	88
4.3.3	Shamanism and Psychopathology.....	90
4.3.4	The Shamanic crisis as Spiritual Emergency.....	93
4.3.5	Summary	95
4.4:	PEAK EXPERIENCES.....	96
4.4.1	The Peak Experience.....	96
4.4.2	Other Models of the Peak Experience	102
4.4.3	The Peak Experience and Psychopathology	105
4.4.4	The Peak Experience as Spiritual Emergency.....	107
4.4.5	Summary	108
4.5:	THE CRISIS OF PSYCHIC OPENING.....	109
4.5.1	Psychic Opening.....	109
4.5.2	Types of Psychic Opening	112
4.5.3	Psychic Opening and Psychopathology.....	118
4.5.4	Psychic Opening as Spiritual Emergency	120
4.5.5	Summary	121
4.6:	THE PAST-LIFE EXPERIENCE.....	122
4.6.1	The Past-life Experience.....	122
4.6.2	Models of the Past-Life Experience	124
4.6.3	The Past-life Experience and Psychopathology.....	129
4.6.4	The Past-life Experience as Spiritual Emergency	131
4.6.5	Summary	132
4.7:	THE NEAR-DEATH EXPERIENCE	133
4.7.1	The Near-Death Experience	133
4.7.2	Models of the Near Death Experience	138
4.7.3	The Near Death Experience and Psychopathology	141
4.7.4	The Near-Death Experience as Spiritual Emergency.....	143
4.7.5	Summary	144
4.8:	SPIRIT POSSESSION.....	145
4.8.1	The Experience of Spirit Possession	145
4.8.2	Theories of Spirit Possession	147
4.8.3	Spirit Possession and Psychopathology	150
4.8.4	Spirit Possession as Spiritual Emergency.....	154
4.8.5	Summary	156
4.9:	PSYCHOLOGICAL RENEWAL THROUGH RETURN TO THE CENTRE.....	157
4.9.1	General Introduction	157
4.9.2	The Central Archetype.....	158
4.9.3	The Renewal Process.....	161
4.9.4	The Renewal Process and Psychopathology.....	165
4.9.5	The Renewal Process as Spiritual Emergency	167
4.9.6	Summary	167

4.10:	THE ALIEN ABDUCTION EXPERIENCE	169
4.10.1	The Alien Abduction Experience.....	169
4.10.2	Models of the Alien Abduction Experience.....	170
4.10.3	The Alien Abduction Experience and Psychopathology.....	176
4.10.4	The Alien Abduction Experience as Spiritual Emergency	178
4.10.5	Summary	179
4.11	Conclusion	180
CHAPTER 5: PSYCHOSIS AND SPIRITUAL EMERGENCY		183
5.1	Brief History of Psychosis and Spiritual/Mystical Experiences.....	183
5.2	Similarities and Differences Between Psychosis and Spiritual/Mystical Experience.....	187
5.3	Difficulties of Differentiation.....	196
5.4	How can Psychosis and Spiritual Emergency be Differentiated?.....	203
5.5	The Importance of Differentiation.....	209
5.6	Conclusion	211
CHAPTER 6: METHOD.....		213
6.1	Introduction	213
6.2	Participants	214
6.3	Materials	214
6.3.1	The Spiritual Emergency Sub-Scales.....	215
6.3.2	The Experiences of Psychotic Symptoms Sub-Scale.....	216
6.3.3	The Social Desirability Sub-Scale	217
6.4	Procedure	217
6.5	Design and Analyses	218
CHAPTER 7: RESULTS.....		220
7.1	The Experience of Psychotic Symptoms Scale: Distribution and Statistics 220	
7.2:	The Individual SE Subscales: Distributions and Statistics	222
7.3:	Relationship between the SE Subscales, Religiosity and Spirituality.....	231
7.4:	Psychotic Episodes and Medication.....	234
7.5:	A Spiritual Emergency Scale.....	236
CHAPTER 8: DISCUSSION.....		241
8.1	Discussion of Results.....	241
8.2	Limitations of the Thesis	246
8.3	Contribution to the Field.....	247
8.4	Suggestions for Future Research	248
8.5	Conclusion	250
REFERENCES.....		253
APPENDIX 1		275
EXTRAORDINARY PHYSICAL, MENTAL AND SPIRITUAL EXPERIENCES ...		275
APPENDIX 2		277
“EXTRA-ORDINARY” EXPERIENCES QUESTIONNAIRE		277
APPENDIX 3		285
LIST OF SCALES AND INCLUDED ITEMS		285

LIST OF FIGURES

Figure 7.1. Frequency distribution for the Experience of Psychotic Symptoms Scale	220
Figure 7.2. Frequency distribution for the Dark Night Subscale.	222
Figure 7.3. Frequency distribution for the Kundalini Subscale.	224
Figure 7.4. Frequency distribution for the Shamanic Crisis Subscale.	224
Figure 7.5. Frequency distribution for the Peak Experience Subscale.	225
Figure 7.6. Frequency distribution for the Psychic Opening Subscale.	225
Figure 7.7. Frequency distribution for the Past-Life Experience Subscale.	226
Figure 7.8. Frequency distribution for the Near-Death Experience Subscale.....	226
Figure 7.9. Frequency distribution for the “Possession” States Subscale.	227
Figure 7.10. Frequency distribution for the Central Archetype Subscale.....	227
Figure 7.11. Frequency distribution for the Encounters with UFOs Experience Subscale.....	228
Figure 7.12. Frequency distribution for the Spiritual Emergency Scale.....	238

LIST OF TABLES

Table 7.1. Descriptive Statistics for the Experience of Psychotic Symptoms Scale and the 10 Spiritual Emergency Scales	221
Table 7.2. Comparison of Mean Score for Experience of Psychotic Symptoms Scale, for Persons at or above Cutoff and for Persons Below Cutoff, for 10 Spiritual Emergency Scales	223
Table 7.3. Inter-correlations for the 10 Spiritual Emergency Subscales Plus Experience of Psychotic Symptoms and the Lie Scale	230
Table 7.4. Comparison of Spiritual Versus Nonspiritual Participants for Six Spiritual Emergency Subscales.....	233
Table 7.5. Comparison of Scores on Experience of Psychotic Symptoms Scale for Three Psychosis Indicators	235
Table 7.6. Factor Loadings and Communalities for the Ten Spiritual Emergency Subscales.....	237
Table 7.7. Comparison of Scores on the Spiritual Emergency Scale for Three Psychosis Indicators	240

ABSTRACT

Psychosis has long been recognised as a severe mental disorder characterised by derangement of personality, disorganised thought, and a loss of contact with reality. Certain mystical and alternate states, which have been practiced throughout history by various cultures, have also been deemed as pathological through the lens of western psychiatry even though many of these states provide beneficial contributions to the individual and their community. A number of similar states have been found in modern society and have been termed “Spiritual Emergencies”. The aim of this research was to determine whether “spiritual emergency” (SE) is a valid concept and to outline the differences between SE and psychosis. One-hundred-and-nine participants from the general public completed a questionnaire developed for this research, comprised of measures of psychosis and ten spiritual emergency subscales. Results indicated that participants who were prescribed medication or previously experienced a psychotic episode scored higher on the SE subscales. One strong factor was found to underlie all the SE subscales and a significant relationship was found between this factor and the measure of psychotic experience. It is open to interpretation as to whether psychosis is nothing more than SE or whether SE is nothing more than psychosis. The implications of these findings are discussed.

CHAPTER 1: INTRODUCTION

1.1 Overview of the Thesis

The term “spiritual emergency” seems to have originated with Christina Grof in the late 1970s (Grof & Grof, 1991, p. 238). It is used to contrast with the concept of “spiritual emergence”, which is “the emergence of a more transpersonal outlook on life accompanied by increased creativity, feelings of peace, and an expanded sense of compassion” (Thalbourne, 2003b, p. 118). Spiritual emergency, on the other hand, is a term used by some transpersonal psychologists to refer to a psychotic-like crisis—sometimes spontaneous, sometimes precipitated by “spiritual”¹ experiences or meditation, that cannot be readily integrated into the person’s psychological framework. Successful resolution of the crisis engendered is said to lead to enhanced spiritual emergence (Thalbourne, 2003b, p. 118).

The notion that some psychiatric states are opportunities for spiritual growth rather than intrinsically destructive psychopathologies has been proposed by a number of earlier researchers:

Roberto Assagioli, the Italian-born founder of psychosynthesis, saw spirituality as a vital force in human life and an essential aspect of the psyche. He interpreted many of the phenomena that mainstream psychiatry treats as psychopathological manifestations to be concomitants of spiritual opening . . . Carl Gustav Jung [e.g., 1968, pp. 208-214] also attributed great significance to the spiritual dimensions

¹ Spiritual experiences will be discussed in Chapter 3.

and impulses of the psyche and created a conceptual system that bridges and integrates psychology and religion. Another important contribution to a new understanding of the relationship between mysticism and human personality came from Abraham Maslow. On the basis of extensive studies of individuals who had had spontaneous mystical, or “peak,” experiences, he challenged the traditional psychiatric view that equated them with psychosis and formulated a radically new psychology. According to him, mystical experiences should not be considered pathological; it seems more appropriate to view them as supernormal, since they are conducive to self-actualisation and can occur in otherwise normal and well-adjusted individuals. (Grof, 1985, p. 367)

There are, described in the literature, at least 10 distinct spiritual emergencies (see Grof & Grof, 1985, 1991). We repeatedly quote from Grof and Grof (1991). These emergencies include (1) Dark Night of the Soul (feelings of fear, a sense of loneliness, experiences of insanity, and a preoccupation with death); (2) the Awakening of Kundalini (powerful sensations of heat and energy streaming up the spine, associated with tremors, spasms, violent shaking, and complex twisting movements); (3) Shamanic Crisis (an emergency which bears a deep resemblance to the initiatory crises of shamans—healers and spiritual leaders of many aboriginal peoples); (4) Episodes of Unitive Consciousness (Peak Experiences: an emergency may occur when a person has mystical experience but lacks real spiritual understanding); (5) Psychic Opening (e.g., awakening of

extrasensory perception: the frequent occurrence and accumulation of psychic events such as precognition and telepathy can be very frightening and disturbing, since they seriously undermine the notion of reality prevalent in industrial societies); (6) “Past-Life” Experience (an emergency occurs when a strong karmic experience begins emerging into consciousness in the middle of everyday life and profoundly disturbs normal functioning); (7) Near-Death Experience (an emergency involves an unusually abrupt and profound shift in the experience of reality in people who are entirely unprepared for this event); (8) so-called “Possession” States (in these, the demonic archetype that causes the experiences is by its very nature transpersonal and represents a necessary counterpoint to the Divine); (9) the Activation of the Central Archetype (also known as “Psychological Renewal Through Return to the Centre”: dramatic experiential sequences that involve enormous energies and occur on a scale that makes these individuals feel they are at the centre of events that have global or even cosmic significance); and (10) Experiences of Close Encounters with UFOs (such experiences and apparent abductions can often precipitate serious emotional, intellectual, and spiritual crises).

1.2 Objectives of the Thesis

The first objective for this research is to present a literature review on psychosis, outline the shortcomings of the conventional medical model and present alternative models. The next objective is to investigate the notion of spiritual emergency in order to determine if it is a valid concept.

This literature review of spiritual emergency (primarily published by the Grofs, 1985, 1991) has been used to construct questionnaire scales to

measure each of these 10 spiritual emergencies. Since conventional psychiatric thinking would describe these emergencies as nothing more than psychosis, a 15-item Experience of Psychotic Symptoms Scale (the EPSS) was also constructed, in order to determine the correlation between this and the spiritual emergency scales.

The 10 spiritual emergency subscales each consisted of between 5 and 13 yes/no items, for a grand total of 84 items. Summary statistics for the EPSS and the 10 spiritual emergency subscales will be presented in the Results section. In addition, a histogram will be presented for each subscale, in order to illustrate the frequency distribution of the subscale scores.

We will also suggest that persons who score more than one standard deviation above the mean of the given subscale be *tentatively* classified as having definitely experienced the relevant spiritual emergency. The appropriate cutoff point will be given, and the mean EPSS score for persons *at or above* the cutoff will be compared with the mean EPSS score for persons *below* the cutoff. ²

The inter-correlations between the 10 spiritual emergency subscales will be examined and factor analysed to determine how distinct the various spiritual emergencies are.

1.3 Underlying Theoretical Perspectives

Transpersonal psychology has emerged from humanistic psychology over the past 30 years in a similar way as the humanistic approach emerged

² Another possibility, used by Cattell, Eber, and Tatsuoka (1970), is to examine those 5% of persons in the high tail of the distribution; however, they may be more extreme than one standard deviation from the mean.

from the earlier behavioural and analytical approaches (Valle, 1989).

Theorists in the field of transpersonal psychology have drawn their knowledge from a wide range of eastern and western religions, philosophies and traditions including shamanism, Buddhism, consciousness research, perennial philosophy, experiential psychotherapy and a number of esoteric and metaphysical practices.

Transpersonal psychology has been defined as "the study of humanity's highest potential, and with the recognition, understanding, and realisation of unitive, spiritual, and transcendent states of consciousness" (Lajoie & Shapiro, 1992, p.91). In a review of definitions in the transpersonal literature, five key themes emerged including: (i) elements of spirituality, (ii) transcendence, (iii) alternate states of consciousness, (iv) that which lies beyond the ego, and (v) reference to one's higher or ultimate potential (Lajoie & Shapiro, 1992). Thus transpersonal psychology not only embraces the fundamentals of humanistic psychology but also embraces the experiences which lie beyond the individual or personal ego and that of the five senses.

The experiences which lie in the transpersonal domain of the psyche involve various non-ordinary states of consciousness which have been systematically studied by a number of ancient traditions:

In the Hindu and devotional traditions, these realms are described as different levels of samadhi [a state of union with universal consciousness]. In the Christian, Sufi, and Jewish mystical traditions, certain texts and maps describe the states of consciousness evoked through prayer, concentration and silence... The Buddhist tradition

offers hundreds of techniques for the opening of consciousness. New realms of consciousness can also open spontaneously through what is called grace, or they may occur under the pressure of circumstance. (Kornfield, 1993)

The non-ordinary state of consciousness is one of the main areas of investigation within transpersonal psychology and presents an extreme challenge to the western medical model, which has long dismissed or pathologised this aspect of human experience. The medical model is seated within the prevailing Newtonian-Cartesian paradigm of reality, which is governed by the laws of cause and effect and maintains three-dimensional space and linear time. Our ordinary waking level of consciousness, which Grof (1988) terms the “hylotropic” mode of consciousness, neatly fits into this reality. Here “matter is solid; two objects cannot occupy the same space; past events are irretrievably lost; future events are not experientially available; one cannot be in more than one place at a time; one can exist only in one temporal framework at a time; a whole is larger than a part; or something cannot be true and untrue at the same time” (Grof, 1988, p. 239). In contrast, the non-ordinary states of consciousness, or “holotropic” states, transcend these narrow boundaries (Grof, 2000) and involve "the experience of oneself as a potentially unlimited field of consciousness that has access to all aspects of reality without the mediation of the senses" (Grof, 1988, p. 239).

In the holotropic state, one’s consciousness is qualitatively changed in a profound way while retaining contact with everyday reality and remaining fully orientated in terms of space and time. At the same time, one’s

consciousness is intensively and overwhelmingly invaded by information from other dimensions of existence, thus one simultaneously experiences two very different realities (Grof, 2000).

The induction of holotropic states can be traced back to the dawn of human history and has played an important role in ancient and aboriginal cultures where vast amounts of time and energy have been dedicated to the development of various mind-altering procedures for ritual and spiritual purposes. However, in spite of overwhelming evidence from historical sources, comparative religion, anthropology and modern consciousness research, mainstream psychiatry maintains the view that holotropic states are pathological and do not distinguish between mystical states and psychosis (Grof, 2000).

A growing number of researchers believe that the current scientific models of the human psyche cannot account for the latest findings in consciousness research and call for an expanded conceptual framework built on an openness of inquiry into new data that challenge traditional beliefs (Grof, 1993). The growing data supporting the view that spiritual emergency is a rapid and chaotic process of psychospiritual growth must be taken into consideration, and new models accounting for the unusual content contained within these experiences need to be constructed.

1.4 Methodology

The first aim of his thesis is to examine the conventional model of psychosis and outline its shortcomings. In order to do this an extensive literature review and analysis of the medical text was undertaken. A broader

literature review provides substantial support for several alternate non-medical models of psychosis which have also been presented.

The next intention of this thesis is to determine the validity of the concept of spiritual emergency. In order to do this an extensive review and analysis of literature relevant to psychospiritual crisis was undertaken. This included literature from such disciplines as theology, psychology, consciousness research, anthropology, sociology as well as the ancient Shamanic and yogic systems.

A questionnaire was also devised to determine if there are any differences between self-reported measures of psychosis and spiritual emergency. The EPSS was constructed using the DSM-IV criteria for psychosis, and the spiritual emergency scales were constructed via the literature review. Further information on the construction of this scale is given in the Methods section (see Chapter 6) and tests for internal and retest validity have also been reported in the appropriate sections.

1.5 Outline of the thesis

Chapter 2 will investigate “psychosis” from both medical and non-medical models including literature from psychiatry, psychology, sociology, mythology, and anthropology as well as the mystical and spiritual literature.

Chapter 3 briefly explores spirituality and mysticism in order to gain a broader perspective of the concepts of spiritual emergence and spiritual emergency. This chapter also introduces the ten subtypes of spiritual emergency which will be used in the remainder of this paper.

Chapter 4 explores in depth the following ten subtypes of spiritual emergency: (1) ego death or dark night of the soul, (2) the awakening of Kundalini, (3) the Shamanic crisis, (4) episodes of unitive consciousness or peak experiences, (5) the crisis of “psychic” opening, (6) “past-life” experiences, (7) near-death experiences, (8) “possession” states, (9) psychological renewal through the central archetype, and (10) UFO phenomena. For each subtype, a range of literature from varying disciplines are reviewed, the experience is described using various models and similarities and differences between the subtype and psychopathology is explored. It is then discussed how each of the subtypes fits into the concept of spiritual emergency.

Chapter 5 will examine the similarities and difference of the “psychotic” and “spiritual emergency” states from a number of frameworks. The chapter discusses the difficulties associated with the differentiation of the two and presents several frameworks, which attempt to do so. Chapter five also discusses the importance of being able to differentiate between psychosis and spiritual emergency including the implications of labelling, psychiatric treatment and medication.

Chapters 6 and 7 outline the procedure for this research, the construction of the questionnaire, the validity of the questionnaire and report the results. Chapter 8 discusses the outcomes of the research, the validity of the concept of SE and its implications for psychiatry. Limitations of this research and suggestions for future research are also discussed.

But first and most importantly it is necessary to gain a solid understanding of the very concepts we are attempting to investigate and the next two chapters will make a brave attempt to do so.

CHAPTER 2: PSYCHOSIS

“Our greatest blessings come to us by way of madness,
provided the madness is given us by divine gift.”

Plato (*Phaedrus*)

2.1 Introduction to Psychosis

The word ‘psychosis’ comes from the Greek *psykhis* meaning “animation, principle of life”. The Latin *psyche* and the Greek *psyche* both represent the “soul, mind, spirit, breath, life, the invisible animating principle or entity which occupies and directs the physical body” and the modern medical term of ‘-osis’ is a suffix used to express ‘a state of disease’. From 1847 ‘psychosis’ came to be known as a ‘mental derangement’, meaning that the invisible animating principle or entity which occupies and directs the physical body is in a state of disease.³

Historically, the term psychosis has received a number of definitions and to date, none have received universal acceptance. For example, in 1860, Neumann summarised psychosis very simply as “There's only one kind of madness, and we call it insanity”. Over the following 50 years, a huge variety of labels were given to psychiatric patients to the extent that the term became scientifically invalid (Neppe, 1993).

A breakthrough occurred in the 1890s with Kraepelin classifying what was previously thought to be a unitary concept of psychosis into two distinct categories: (1) ‘manic depression’, more recently known as bipolar disorder and (2) ‘dementia praecox’, which was later renamed ‘schizophrenia’ in 1911 by Bleuler (Bentall, 2004). Bleuler’s concept of schizophrenia differed from the

³ <http://www.etymonline.com/index.php?term=psychosis>

earlier dementia praecox in two ways, (1) there was a perceived split between cognitive and emotional functions and (2) specific symptoms were thought to occur at specific times. This differed from Kraepelin's concept of an ongoing deteriorating illness, presenting in the young and ultimately leading to intellectual deficit (Neppe, 1993).

More recently, according to the DSM-IV(TR):⁴

The narrowest definition of *psychotic* is restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature.

A further, less restrictive definition in the DSM-IV(TR) "... would also include prominent hallucinations that the individual realizes are hallucinatory experiences," with a still broader definition including "... other positive symptoms of Schizophrenia (i.e., disorganized speech, grossly disorganized or catatonic behaviour)."

A more neutral definition of psychosis not entrenched in the psychiatric worldview comes from Nelson (1994) who defines psychosis as "any one of several altered states of consciousness, transient or persistent, that prevent integration of sensory or extrasensory information into reality models accepted by the broad consensus of society, and that lead to maladaptive behaviour and social sanctions" (p. 3).

It is difficult to measure how widespread the occurrence of psychosis is as there are considerable numbers of people who exhibit psychotic like

⁴ Diagnostic and Statistical Manual - Text Revision (DSM-IV-TR™, 2000)

symptoms who never come into contact with the mental health services. However, it is believed that approximately 3% of the population will experience episodes of psychosis, with a usual onset of late teens or early 20s and approximately 1% is likely to receive a diagnosis of schizophrenia with another 1% receiving a diagnosis of bi-polar disorder, both of which exhibit psychotic symptoms (British Psychological Society, 2000).

With over 100 years of research into the cause(s) of psychosis, no positive consensual outcome has been achieved. However, it is thought that a number of interacting factors within the psychological makeup of the person may contribute to the experience of psychosis, including social, environmental and biological factors. These theories will be discussed later in this chapter.

2.2 Psychosis and the DSM-IV(TR)

Psychosis is frequently expressed as a symptom of mental illness and the DSM-IV(TR) lists the following psychiatric disorders as having psychotic symptoms as the defining feature:

Schizophrenia is a disorder that lasts for at least 6 months and includes at least 1 month of active-phase symptoms (i.e., two [or more] of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behaviour, negative symptoms; p. 298).

Schizophreniform Disorder is characterized by a symptomatic presentation that is equivalent to schizophrenia except for its duration

(i.e., the disturbance lasts from 1 to 6 months) and the absence of a requirement that there be a decline in functioning (p. 298).

Schizoaffective Disorder is a disorder in which a mood episode and the active-phase symptoms of schizophrenia occur together and were preceded or are followed by at least 2 weeks of delusions or hallucinations without prominent mood symptoms (p. 298).

Delusional Disorder is characterized by at least 1 month of non-bizarre delusions without other active-phase symptoms of schizophrenia (p. 298).

Brief Psychotic Disorder is a disorder that lasts more than 1 day and remits by 1 month (p. 298).

Shared Psychotic Disorder is characterized by the presence of a delusion in an individual who is influenced by someone else who has a longer-standing delusion with similar content (p. 298).

In **Psychotic Disorder Due to a General Medical Condition**, the psychotic symptoms are judged to be a direct physiological consequence of a general medical condition (p. 298).

In **Substance-Induced Psychotic Disorder**, the psychotic symptoms are judged to be a direct physiological consequence of a drug of abuse, a medication, or toxin exposure (p. 298).

Psychotic Disorder Not Otherwise Specified is included for classifying psychotic presentations that do not meet the criteria for any of the specific psychotic disorders defined ... or psychotic symptomatology about which there is inadequate or contradictory information (p. 298).

According to the DSM-IV (TR), Psychotic symptoms are often characterised as positive or negative. The positive symptoms appear to reflect an excess or distortion of normal functioning and are often responsible for the stress associated with the condition. Positive symptoms include:

- Delusions – distortions or exaggerations of inferential thinking
- Hallucinations – distortions or exaggerations of perception
- Disorganised speech – distortions or exaggerations of language and communication
- Disorganised or Catatonic Behaviour – disorganised or a marked decrease in behaviour

Negative symptoms appear to reflect a diminution or loss of normal functions and generally appear to be responsible for much of the chronic and long-term disability associated with the condition. Negative symptoms include:

- Affective flattening – restrictions in the range and intensity of emotional expression
- Alogia – restrictions in the fluency and productivity of thought and speech
- Avolition – restrictions in the initiation of goal-directed behaviour.

The DSM-IV(TR) definitions for the positive symptoms are given below:

Delusions

Delusions are erroneous beliefs that usually involve a misinterpretation of perceptions or experiences. Their content may include a variety of themes (e.g., persecutory, referential, somatic, religious, or grandiose).

Persecutory delusions are most common; the person believes he or she is being tormented, followed, tricked, spied on, or ridiculed.

Referential delusions are also common; the person believes that certain gestures, comments, passages from books, newspapers, song lyrics, or other environmental cues are specifically directed at him or her.

Bizarre delusions are considered to be especially characteristic of Schizophrenia. Delusions are deemed bizarre if they are clearly implausible and not understandable and do not derive from ordinary life experiences.

Delusions that express a loss of control over mind or body are generally considered to be bizarre; these include a person's belief that his or her thoughts have been taken away by some outside force ("thought withdrawal"), that alien thoughts have been put into his or her mind ("thought

insertion"), or that his or her body or actions are being acted on or manipulated by some outside force ("delusions of control").

Hallucinations

Hallucinations may occur in any sensory modality (e.g., auditory, visual, olfactory, gustatory, and tactile), but auditory hallucinations are by far the most common. Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the person's own thoughts.

Hallucinations that occur while falling asleep (hypnagogic) or waking up (hypnopompic) are considered to be within the range of normal experience.

Certain types of auditory hallucinations (i.e., two or more voices conversing with one another or voices maintaining a running commentary on the person's thoughts or behaviour) have been considered to be particularly characteristic of schizophrenia.

Disorganised Speech

A further symptom of psychosis, disorganised thinking is thought to be the single most important feature of schizophrenia. As thoughts are based primarily on the individual's speech, the concept of disorganised speech is used as a measure of disorganised thought.

The speech of individuals with schizophrenia may be disorganized in a variety of ways. The person may "slip off the track" from one topic to another ("derailment" or "loose associations"); answers to questions may be obliquely related or completely unrelated ("tangentiality"); and, rarely, speech may be so severely disorganized that it is nearly incomprehensible and resembles

receptive aphasia in its linguistic disorganization ("incoherence" or "word salad").

Because mildly disorganized speech is common and nonspecific, the symptom must be severe enough to substantially impair effective communication.

Disorganised or Catatonic Behaviour

Grossly disorganised behaviour may manifest itself in a variety of ways, ranging from childlike silliness to unpredictable agitation. Problems may be noted in any form of goal-directed behaviour, leading to difficulties in performing activities of daily living such as preparing a meal or maintaining hygiene. The person may appear markedly dishevelled, may dress in an unusual manner (e.g., wearing multiple overcoats, scarves, and gloves on a hot day), or may display clearly inappropriate sexual behaviour (e.g., public masturbation) or unpredictable and untriggered agitation (e.g., shouting or swearing).

Catatonic motor behaviours include a marked decrease in reactivity to the environment, sometimes reaching an extreme degree of complete unawareness (catatonic stupor), maintaining a rigid posture and resisting efforts to be moved (catatonic rigidity), active resistance to instructions or attempts to be moved (catatonic negativism), the assumption of inappropriate or bizarre postures (catatonic posturing), or purposeless and unstimulated excessive motor activity (catatonic excitement).

The DSM-IV(TR) recognises the importance of taking people's religious and cultural backgrounds into account.

Some cultures have widely held and culturally sanctioned beliefs [e.g., voodoo or sorcery] that might be considered delusional in other cultures. The content of delusions also varies in different cultures and subcultures (p. 326).

Hallucinations may be a normal part of religious experience in certain cultural contexts (p. 300).

A further feature of psychosis is the lack of insight that usually accompanies the unusual experiences and behaviours of the psychotic illness.

Evidence suggests that poor insight is a manifestation of the illness itself rather than a coping strategy. This symptom predisposes the individual to non-compliance with treatment and has been found to be predictive of higher relapse rates, increased number of involuntary hospital admissions, poorer psychosocial functioning, and a poorer course of illness (p. 304).

Criticisms of the DSM Classification System

The DSM classification system has been widely criticised on a number of counts: (1) There is no valid measure of internal consistency or reliability; (2) there is no external validating criteria; (3) the decision of who is and who is not mentally ill is subjective; (4) it is based on the fact that we all share the same consensus reality; which leads to the subject matter of this thesis that

(5) much research indicates that 'psychosis' is an altered state of consciousness that has the potential for positive growth.

1 There is no valid measure of internal consistency and reliability: The internal consistency and reliability of the DSM as a diagnostic system for mental illness have been questioned. In a chronological review of the history of the DSM, Bentall (2004) claims that in general "modern psychiatric diagnoses fail to meet adequate standards of reliability (p. 68). Also, it is widely known in modern psychiatric practice for an individual to be given one diagnosis during one admission or by one psychiatrist, then to be given a different diagnosis on a further admission or by different psychiatrist. This common practice undermines the consistency of the DSM as a diagnostic tool and supports Bentall's claim that "psychotic symptoms cannot be explained in terms of a single underlying disease process" (2004, p. 75).

2 There is no external validating criteria: Although psychiatry uses the medical model for organic mental disorders, it also uses the model to diagnose disorders in which no biological cause can be found. Despite over 100 years of research into the genetic or biological cause of psychotic disorders, there has been no clear identification of underlying pathology (Chua & McKenna, 1995; Bentall, 2004). A further summary of psychiatric research by Siebert (2000) indicated that neurologists are unable to confirm the presence or absence of schizophrenia with laboratory tests as they can with neurological diseases (e.g., Alzheimer's or Parkinson's disease). With no

external validating criteria how can a psychotic disorder be assumed to be of biological origin and be classified using a medical diagnosis?

3 Making the decision of who is and who is not mentally ill subjective:

Although 'madness' has existed in all societies, the words used to describe it, the way it is responded to and the cause that is attributed to it all differ over time and place. While some societies counsel and tolerate the deviance in behaviour, the West using its biologically oriented classification system, segregates and medicates (Pilgrim, 1990). Some believe that the decision of who is and who is not mentally ill is wholly subjective on the part of the doctor (Laing, 1967; Grof, 2000). Laing (1967) criticises psychiatrists, as they do not seek to understand the patient's communication and miss the deeper meaning and connection of the inner and outer experience.

4 Based on the assumption that we all share the same consensus reality

The concept of illness implies a deviation from some clearly defined norm. Whatever the norm, Szasz (1974) believes that it must encompass psychosocial, ethical and legal concepts. In the case of mental illness where there is no biological origin, the diagnosis is made on the deviance from 'normal' behaviour. Szasz is most concerned with who defines these norms and who defines the deviations from these norms. He believes that the psychiatrist is committed to a particular notion of reality and judges the patient's behaviour in light of these assumptions. Szasz is also concerned with the social implications of giving people psychiatric diagnoses. He

believes that these labels unjustly medicalise different behaviours and different views of reality.

2.3 Medical Model of Psychosis

Biological factors such as brain tumours, illness, ingestion of street drugs or changes in brain chemistry have been implicated in the cause of psychotic experience. However, the evidence is often weaker than claimed and research into genetics, brain structure and chemistry as well as environmental and physical causes has not led to clear conclusions.

This thesis will examine a number of models which attempt to explain the phenomenon of psychosis. First, the medical model, which is based on the assumption that psychotic symptoms are pathological, will be presented. In this model psychotic symptoms are seen as the product of chemical imbalances, the result of neurological changes within the brain or the product of an underlying medical condition. Next, several non-medical models including the continuum of mental health and mental illness model, the stress vulnerability model, the Jungian perspective as well as the anthropological, Shamanic and Buddhist perspectives will be presented.

Psychosis Due to a Medical Condition.

The DSM-IV(TR) lists a number of medical conditions that are known to cause psychotic symptoms. These include:

- Neurological conditions such as neoplasms, cerebrovascular disease, Huntington's disease, multiple sclerosis, epilepsy, auditory or visual

nerve injury or impairment, deafness, migraine and central nervous system infections.

- Endocrine conditions such as hyper- and hypothyroidism, hyper- and hypoparathyroidism and hyper- and hypoadrenocorticism.
- Metabolic conditions including hypoxia, hypercarbia and hypoglycemia.
- Fluid or electrolyte imbalances, hepatic or renal diseases, and autoimmune disorders with central nervous system involvement.

The diagnosis of psychosis due to a medical condition can only be made when the following criteria are met:

- Prominent hallucinations or delusions
- There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition
- The disturbance is not better accounted for by another medical disorder
- The disturbance does not occur exclusively during the course of a delirium

Given the wide variety of underlying medical causes, the prevalence of psychosis due to a medical condition is difficult to assess. However, it has been suggested that psychotic symptoms may be present in up to 20% of patients presenting with untreated endocrine disorders, 15% of patients with systemic lupus erythematosus (chronic autoimmune disease), and up 40% or

more of patients presenting with temporal lobe epilepsy. Psychosis due to a medical condition may be a single isolated state, or it may be recurrent, cycling with the status of the medical condition. The treatment of the underlying medical condition often results in the resolution of the psychotic symptoms. However, in some cases the psychotic symptoms persist after the underlying medical condition have been cured (DSM-IV(TR)). Research indicating that psychosis can be triggered by a huge variety of medical conditions indicates that psychosis is not a mental illness in itself.

The Dopamine Hypothesis

Psychosis has traditionally been linked to the neurotransmitter, dopamine. The dopamine theory has received much interest over the past 20 years and posits that psychotic disorders, such as schizophrenia or bi-polar, may result from an overproduction of dopamine in the brain. This theory is based on two observations: (1) Some neuroleptic medications affect the dopamine balance and can induce Parkinsonism, which is related to decreased levels of dopamine; (2) Drugs which increase dopamine production, such as amphetamines, can also trigger psychotic-like experiences.

However, the connection between dopamine and psychosis is thought to be complex and current research has not advanced far enough to draw firm conclusions. The first point does not explain why the neuroleptic drugs have an immediate effect on dopamine but take time to reduce the psychotic symptoms, and the second point does not address the fact that while amphetamines can lead to psychotic experiences, this does not mean that they are the only cause. Even if a reliable relationship were found between a

biochemical abnormality and a mental state, this would not determine the cause and effect (British Psychological Society, 2000).

Psychosis and the Brain

Considerable research has been devoted to examining possible abnormalities in brain structure or function in relation to mental illness exhibiting psychotic symptoms. In a review of CT, MRI, post-mortem and functional imaging studies, to determine which structural and/or functional brain abnormalities are present in schizophrenia, it was found that the only well established abnormality is lateral ventricular enlargement. This was a minor abnormality, which may be better understood as a risk factor rather than a causative lesion. Findings from functional imaging, indicated that schizophrenia shows complex alterations in regional patterns of activity rather than a deficits in function (Chua & McKenna, 1995).

The issue of lateralised hemispheric dysfunction due to mental illness has also been reported. Results from a recent study measuring motor asymmetry in older patients with psychosis supported previous research indicating that schizophrenia may be associated with left hemisphere dysfunction where bipolar disorder may be associated with right hemisphere dysfunction (Lohr & Caligiuri, 1997).

However, increased levels of right hemispheric functioning have also been found in healthy people. For example, individuals displaying paranormal beliefs have demonstrated higher right hemispheric activation and reduced hemispheric asymmetry of functional complexity (Pizaagalli, et al., 2000). Further, increased temporal lobe activations has been shown in people

reporting yes to questions indicating temporal lobe lability such as "hearing inner voices" and "feeling as if things were not real" (Makarec & Persinger, 1985).

More recent research has tackled the question of whether the neuro-anatomical abnormalities sometimes found to be associated with psychotic disorders, predate the onset of symptoms or progressively develop over the course of the illness. Individuals expressing prodromal (early) symptoms seen to be at high-risk for the development of psychosis were subjected to an initial MRI for a base line reading with another after 12 months. Individuals who developed psychosis showed a decrease in grey matter in various parts of the brain indicating that some grey matter abnormalities found to be associated with psychosis predate the onset of symptoms (Pantelis et al., 2003).

Siebert (1999, cited in Siebert, 2000) believes that the majority of people diagnosed with schizophrenia display no neuropathological or biochemical abnormalities, while some people with no symptoms of schizophrenia display the same biophysiological abnormalities as some people with schizophrenia. Even when differences have been found in the brains of people who have been diagnosed with schizophrenia, or other psychiatric disorders displaying psychotic symptoms, it is important to realise that the effect of psychiatric medication is not always taken into account (British Psychological Society, 2000).

In conclusion, the medical model covers a number of biological theories on the cause or origin of psychotic illness but to date there are no clear-cut answers. This brings into question the validity of the medical model as well as the diagnosis process. Given that there has been so much

research invested in the cause of schizophrenia over the past 100 years it may be fitting to conclude this section with Mortimer (1992) who emphasises that:

In some quarters schizophrenia has gained the reputation of a graveyard of research. Few findings stand the test of time, most of the pieces of this particular jigsaw seem to be missing, and it is not easy to make sense of those that are available. Even 'hard' scientific findings fail to be replicated... (p.293).

2.4 Non-Medical Models of Psychotic-like Behaviour

A number of non-medical models have been proposed to explain the behaviours similar to, or the same as, those that often get labelled as psychotic. This thesis will present an overview of a few of these models, including the continuum of mental health and mental illness model, the stress vulnerability model, the Jungian perspective, as well as the anthropological, Shamanic and Buddhist perspectives.

A Continuum of Mental Illness and Mental Health

The mainstream psychiatric profession believes that the experiences and behaviours of individuals diagnosed with 'psychotic' disorders are qualitatively different from those of 'normal' people. However, a growing amount of research indicates that there is no clear boundary between mental health and mental illness and that 'psychotic' experiences are the extreme

expression of traits that are widely expressed in the 'normal' population (Claridge, 1985; 1994).

Research into the prevalence of psychotic like traits or 'schizotypy' in the normal population has suggested a continuum from healthy functioning through to 'florid' psychosis. Here, schizophrenia is seen as a breakdown in healthy functioning. It is represented as a personality dimension varying across the 'normal' population, consequently blurring the distinctions between symptoms and traits. These have been measured psychometrically in the normal population with individuals receiving high scores resembling individuals reporting psychotic experiences for a number of measures (e.g., attention and reasoning; Claridge, 1994).

Also, numerous healthy, well functioning individuals have been known to encounter 'psychotic-like' experiences. Tien (1991) reports that 10-15% of the normal population have had some kind of hallucinatory experience in their lives. Many healthy individuals also experience unusual phenomena (e.g., so-called hallucinations and delusions) associated with 'profound spiritual experiences', which they interpret as positive and purposeful (Jackson, & Fulford, 1997). These findings provide further support for the notion of a continuum between 'normal' and 'psychotic' behaviour and experience.

Further support of the continuum theory comes from van Dusan (1985), a clinical psychologist who recorded individuals' experiences during their psychotic episodes. After years of in-depth interviews he came to the conclusion that the psychotic condition is an exaggerated picture of everyone's situation and that mental illness is simply the gross end of a continuum of conditions that make one fit poorly into society.

Stress Vulnerability

Recent research has suggested that biological, psychological and social factors all make a contribution to the onset of psychotic illnesses. In this model, it is believed that individuals may have differing levels of vulnerability to the occurrence of psychotic experiences. Subsequently, the level of stress required to trigger a psychotic episode in one person might not affect another in the same way (British Psychological Society, 2000).

Research has revealed that psychotic experience can be triggered by episodes of extreme stress including major positive or negative events. For example, many people displaying psychotic symptoms have experienced abuse or trauma at sometime in their life. However, evidence has also been found suggesting that psychotic experiences can be triggered by a minor event. In this situation, it is likely that the psychosis may be maintained by the person's situation or their reaction to the initial experience (British Psychological Society, 2000).

It has also become apparent that the people's circumstances play a large role in the diagnosis of psychotic illness with people from disadvantaged backgrounds, especially young men, seeming to be at greatest risk (British Psychological Society, 2002). The role of family relationships in the development of psychotic illness has also been explored (Laing, 1967) and there is evidence indicating that if people experiencing mental illness live in a calm and relaxed home environment that their illness is less likely to return (Warner, 1985).

Psychosocial Model of Psychosis

Support for the psychosocial model comes from Warner (1985) whose research into schizophrenia and society suggests that psychosis is a disease of societies with a wage economy. He explains that although individuals living in cultures based on subsistence economies do exhibit psychotic-like behaviour, they often fully recover from the 'illness' within nine months. This may be due to several factors. The (usually) young person is not stigmatised, loses no status, takes on simple tasks and is given full family and community support until they fully recover. Some individuals may also take on the role of shaman's apprentice, where they will learn how to enter and exit altered states of consciousness without experiencing a psychotic episode.

Although Warner believes that individuals may be genetically predisposed to psychosis, he also believes that in most cases, environmental stressors trigger the episode and the lack of environmental stressors can aid in recovery. His research indicates that in general, there is an increase in schizophrenia among people from poor, working class, stressful, city environments. He also found a relationship between the state of economy and outcome of the illness, with less recovery in times of unemployment. Alternately, individuals living in a low stress environment surrounded by supportive, non-intrusive, non-critical people are more likely to recover.

Laing (1967) also believed that the environment played a role in psychotic behaviour. Laing argued that the experience and behaviour often labelled as 'psychotic' is a learnt strategy used in order to live in an unliveable situation. He believed that people in this state are often in a situation where they are under considerable contradictory and paradoxical pressures and

demands both internally and externally. Laing believed that the seemingly incomprehensible verbal and non-verbal communication was a valid expression of distress and believed that it could be understood if the therapist took time to find the meaning in the symbolic language. Laing states that “sanity today appears to rest very largely on a capacity to adapt to the external world – the interpersonal world, and the realm of human collectives (Laing, 1967, p.116).

As well as recognising the meaningful content behind the unusual speech and behaviour, Laing believed that the psychotic episode could be transformative in nature and should be recognised as a break through rather than a break down. Laing was also critical of the mainstream psychiatric community as they diagnosed the psychotic disorder by the exhibited behaviour, with no medical basis but treated it biologically with medication.

The Jungian Perspective

Jung (1960a, 1966a, 1966b) maintained that during the psychotic episode, the dream takes place of reality. In other words, the conscious awareness moves from the external physical world to the internal world, which is then experienced as one’s ‘reality’. This is said to occur when the deeper functions of the psyche, or the archetypal-affect images, are activated and overwhelm the individual’s consciousness. This usually takes place when the personality or culture is in a position of great stress and there is an urgent need for a new orientation in the psyche. From this perspective, Jung (1960a, 1966a, 1966b) argues that any delusional content is not pathological and can

be comprehended if one has an understanding of the individual's background and emotional state (Perry, 1999).

Working from the Jungian perspective, Perry (1999) believes that this process constitutes a shift in energy rather than being a form of pathology. According to Perry, when faced with a state of acute distress, the psyche finds itself in an urgent need to reorganise the Self. During this process, vast amounts of energy are drawn away from higher functioning and stir the deepest levels of the psyche. The focus of this activation is known as the Self, the Centre, or the central archetype. When activated, the individual's awareness is flooded with rich archetypal imagery which shows striking parallels to classical myths and rituals of antiquity, particularly the 'ceremonial pattern of sacral kinship'.⁵ Perry (1990) believes that whereas these myths are the metaphors for the journey into the psyche, psychosis *is* the journey into the psyche.

Although the exploration of the imagery experienced during the psychotic episode is viewed as 'feeding the delusional system', Perry's deep psychological work with individuals in acute stages of psychosis revealed that many of the individuals experienced a negative self image and an impoverished world outlook. Perry claimed that it was the pre-psychotic personality that was the true source of the 'psychotic illness' and it was the 'psychotic' process itself, which helped the person to break free of past contractions and heal the negative self-image (Perry, 1999).

Some psychiatrists have criticised mainstream psychiatry for dismissing the imagery present in the 'psychotic' episode as pathological.

⁵ See also chapter 4.9.

Grof (2000) questions how pathological processes in the brain can possibly produce such elaborate, culturally specific and rich imagery in such a vast number of individuals. More recently, Breggin (2004) affirms that people with psychotic disorders, such as schizophrenia, often speak in metaphoric language, which requires symbolic and abstract thinking. This kind of processing necessitates the function of the higher cortical structures in the brain, which is not available in individuals with real brain disease (e.g., Alzheimer's disease).

Anthropological Perspective of Psychotic-like Experience

According to various indigenous and tribal groups, psychotic illnesses are the result of losing part of one's soul. Trauma often plays a role in this process. It is said that when an individual experiences trauma, part of the soul detaches as a defence mechanism to protect the individual from the full impact of the wound. Although what is considered trauma varies with each person, it is the individual's experience with trauma that determines if there is to be a loss of soul or not (Ingerman, 1991).

For indigenous Australians mental illness is traditionally attributed to external forces or reasons (Westerman, 1997), such as doing something that is seen as wrong in the eyes of their culture. Their notion of wellness is holistically and ecologically based and covers a wide range of personal and emotional features, all which play a role in wellness. When there is a weakness in wellness, the individual is predisposed to illness. With the onset of this illness further reducing wellness, and opening a possibility for

malevolent spirits to influence the behaviour of a person (Vicary & Westerman, 2004).

While this type of 'possession' is common in many indigenous cultures, in the West possession is not considered 'normal'. Essentially, a belief in possession and the resulting typical 'possession-like' behaviours may result in various diagnoses such as delusional, dissociative and psychotic disorders.

It should be noted that updates from the DSM-III onwards have attempted to take cultural differences into consideration but whether psychiatrists have a thorough understanding and put into practice their knowledge of cross-cultural differences is a different matter. Some health professionals are still challenging the psychiatric diagnostic system and question whether experiences such as possession are "best explained within the conceptual framework of Western psychiatry, or are they best explained anthropologically as manifestations of structural and functional elements operating in the societies in which they are found" (Simons, 2001).

For individuals experiencing non-ordinary states of consciousness such as 'possession', giving them a pathological label may lead to further undue stress.

The concept of what constitutes a 'healthy mind' differs considerably from one culture to another...How devastating it can be to affix the label of 'mental illness' to any extraordinary state of consciousness! A dissociative state of mind does not necessarily qualify an individual for being put into a straight jacket. Many dissociative states occur in Southeast Asia, for example, in a culturally conditioned and controlled setting (Heinze, 1982, pp. 28-29).

Shamanistic Perspective of Psychotic-like Experience

Historically, the non-ordinary states of consciousness, which play a role in a number of Shamanic rituals, have also been attributed to mental illness.⁶ Anthropological accounts have recorded that curious eating habits, continuous singing, wild dancing and babbling confused words are all elements of the Shamanic initiatory crisis. Within the Shamanic culture, these crises are not seen as mental illness but are interpreted as one's call to become a shaman (Halifax, 1979). Despite the fact that approximately 90% of the world's cultures have various rituals for the exploration of non-ordinary states of consciousness, it remains a common assumption within psychiatry that these states, and the people who experience, them are pathological (Walsh, 1993).

These non-ordinary states of consciousness serve a healing and transformative function within the individual and the society in which it is practiced.

The healing image that the shaman projects is of disease as a manifestation of the transformative impulse in the human organism. The crisis of a powerful illness can also be the central experience of the shaman's initiation. It involves an encounter with forces that decay and destroy. The shaman not only survives the ordeal of a debilitating sickness or an accident, but is healed in the process. Illness then becomes the vehicle to a higher plane of consciousness. The evolution from the state of psychic and physical disintegration to shamanising is

⁶ See also Chapter 4.3.

effected through the experience of self-cure. The shaman – and only the shaman – is a healer who has healed himself (Halifax, 1979).

There are vast cultural differences in what is considered an appropriate expression of illness or distress. In shamanism, for example, the powerful initiation illness is the vehicle for healing, not that which needs to be healed. If this process is labelled as a mental illness and not allowed to proceed until its natural conclusion, there lies a lost opportunity for self-transformation and healing and an unfortunate demise into mental illness.

Buddhist Perspective on Psychotic-like Experience

One of the defining factors of psychosis is a loss of contact with reality. However, what is considered real for one person or one culture may not be perceived as real for another. Our understanding of reality is conditioned by our political, cultural and religious orientations and varies across time and culture. What we believe to be real and what we believe to be 'normal' may also affect the way we view mental health and illness.

Within the Western model we recognize and define psychosis as a suboptimal state of consciousness that views reality in a distorted way and does not recognise that distortion. It is therefore important to note that from the mystical perspective our usual state fits all the criteria of psychosis, being suboptimal, having a distorted view of reality, yet not recognizing that distortion. Indeed from the ultimate mystical perspective, psychosis can be defined as being trapped in, or attached

to, any one state of consciousness, each of which by itself is necessarily limited and only relatively real (Walsh, 1980, p. 665).

According to Buddhist philosophy the true nature of reality is obscured by our quality of mind. Yeshe (2005) explains that disturbances arise from the mind due to its tendency to exaggerate or underestimate the qualities of the person or object it perceives. Buddhists believe that if an individual has a fundamental inability to see reality, and/or understand their own true nature, psychological problems may arise. Yeshe (2005) suggests that western psychology is too narrow and only recognises a problem once an individual becomes emotionally disturbed.

This brief exploration into non-medical perspectives of psychotic-like illness has demonstrated that although it may be a distressing experience, it is often viewed in a more positive light as a purposeful movement toward wholeness or a reorganisation of the self. From this viewpoint, psychosis is not seen as a mental illness but as a vehicle for healing and transformation. Alternately, what we believe to be a state of wellness in our modern western society is viewed as a psychotic state by the mystical tradition.

2.5 Conclusion

For more than 100 years psychiatry has been dominated by the western medical model. During this time many indigenous and socially sanctioned rituals (e.g., the journeys into non-ordinary states of consciousness), have been classified as mental illness. These labels are

given by fitting the unusual behaviour into the strict set of diagnostic criteria as set out in the DSM.

However, since its conception the DSM classification system has also had its critics. Research has indicated that psychosis is not a clear-cut phenomenon as is often believed. It has been demonstrated that psychiatrists do not all agree on what is 'normal' and what is 'psychotic' behaviour and that this line varies across cultures and over time.

A good example of this variation over time can be seen in relation to the near death experience (NDE).⁷ Many years ago when doctors began hearing reports of NDEs, it was assumed that the 'hallucination' was brought on by anaesthetic or by means of a distressed brain (Ring, 1985). However, with over 30 years of research into this phenomena and a large number of verified out-of-body experiences accompanying the NDE, it seems that the NDE can no longer be dismissed as a product of anaesthesia or brain dysfunction.

Scientific enquiry has also revealed that there is a continuum of psychotic symptoms and they often occur in healthy well-functioning people. However, in general, mainstream western psychiatry still tends to see psychosis in strict terms. This chapter has also indicated that what is believed to be a state of 'mental health' in light of the prevailing western medical model can be understood as psychopathology from the mystical and Buddhist perspectives.

Acceptance of these different perspectives and opinions, coupled with an understanding of the idea of shared and non-shared realities (Grof, 1993),

⁷ See also Chapter 4.7.

may lead to a re-evaluation of certain experiences currently labelled pathological, so that they may be seen in a less judgemental light. Grof (2000) proposes that there is a desperate need to transcend the narrow understanding of the psyche that is currently maintained by mainstream psychiatry in order to gain an accurate understanding of the inner human process and that which it currently labels as 'psychotic'.

CHAPTER 3: SPIRITUAL EMERGENCY

“At first, when any of them is liberated and compelled suddenly to stand up and turn his neck around and walk toward the light, he will suffer sharp pains; the glare will distress him, and he will be unable to see the realities of which, in his former state, he had seen but the shadows.”

Republic
Plato

3.1 Introduction to Spirituality

Before discussing the notion of spiritual emergence or emergency we need to first gain an understanding of what is meant by “spiritual”. This very idea in itself is fraught with difficulty as there are so many schools of thought, all having their own frameworks and interpretations of the “spiritual”.

Historically (c.1250) the word spirit means “animating or vital principal in man and animals” and the Latin *spiritus* is said to be of the soul, courage, vigour and breath.⁸ The word soul is of uncertain origin but has been described as “the spiritual and emotional part of the person”.⁹ Spiritual means “of or concerning the spirit”, and comes from the Latin *spiritualis*, “of breathing, of the spirit”.¹⁰

Although this thesis is primarily concerned with spirituality rather than religion, it is important to briefly define religion and acknowledge its relationship with spirituality. Traditionally, religion has been identified as an institutionalised system of relating to God and leading to salvation and religions have been generally recognised as cultural systems containing

⁸ Spirit. <http://dictionary.reference.com/browse/spirit> (accessed: November 06, 2007).

⁹ Soul. <http://dictionary.reference.com/browse/soul> (accessed: November 06, 2007).

¹⁰ Spiritual. <http://dictionary.reference.com/browse/spiritual> (accessed: November 06, 2007).

socially shared patterns of beliefs and behaviours, often based on a founding revelation or revelatory insight. They are concerned with that which the participating group considers ultimately important (e.g., honouring ancestors or achieving enlightenment; Schneider, 2003). Moreover,

...religions are culturally institutionalised in the form of *creed*, or what the group believes about the nature and functioning of personal, cosmic, and transcendent reality; *code*, or what the group holds to be obligatory or forbidden in order to live in accord with ultimate reality; and *cult*, or how the group symbolically expresses its dependence upon ultimate reality whether that be a personal God, the cosmos itself as sacred, the ancestors, or some other transcendent or quasi-transcendent reality. (Schneider, 2003, p.170)

Before the recent division between spirituality and religion, 'spirituality' was recognised as the intense and personal core of religious life (Tacey, personal communication, February 4, 2008). However, in recent years, many people have denied institutional religion in favour of a personal spirituality. Schneider (2003) believes that for many people this repudiation is not of the religious traditions or the religion itself, but rather the denominational belonging. "This contemporary conflict between spirituality and religion is fueled by the dynamics of postmodernity and ... arises primarily when religious tradition is reduced to and equated with its institutionalisation so that the failures of the latter seem to invalidate the former" (p. 180).

Schneider (2003) outlines three models most commonly used to describe the relationship between spirituality and religion in the West. Religion and spirituality are often seen as (1) two distinct, unrelated concepts, (2) conflicting realities, related to one another in inverse proportions, or (3) two aspects of the same enterprise, essential to one another, constituting a single reality, yet often in tension with one another.

Schneider defines spirituality as "the experience of conscious involvement in the project of life-integration through self-transcendence toward the ultimate value one perceives" (2003, p.166). Viewed in this way, spirituality implies a personal lived reality rather than an abstract idea, theory or ideology. It is an ongoing and coherent approach to life, a conscious and pursued involvement in the experience, an ongoing holistic project of life-integration involving body and spirit, emotions and thought and is "pursued by consistent *self-transcendence toward ultimate value*" (p.167)

Some believe that spirituality comprises several components including (1) a transcendental dimension, (2) a meaning and purpose in life, (3) a mission in life, (4) sacredness in life, (5) material values, (6) altruism, (7) high ideals, (8) awareness of the tragic and (9) the fruits of spirituality (Elkins, Hedstrom, Hughes, Leaf, & Saunders, 1988, pp.8-10).

(1) The transcendent dimension is a natural extension of the conscious self into the regions of the unconscious or greater Self. Here, the individual has an experientially based belief and harmonious contact with an "unseen" world.

- (2) The spiritual individual has an authentic sense that life has meaning and one's own existence has purpose.
- (3) The spiritual individual feels a sense of responsibility to life and believe they have a calling to answer, a mission to accomplish or a destiny to fulfill.
- (4) The spiritual individual believes that the sacred is in the ordinary, all life is holy and experiences a sense of awe, reverence and wonder in the everyday setting.
- (5) The spiritual person appreciates the material but does not seek satisfaction from them as they know that ultimate satisfaction is found not in the material but in the spiritual.
- (6) The spiritual person is touched by the pain and suffering of others, they have a strong sense of social justice and is committed to altruistic love in action.
- (7) The spiritual person has high ideals, is committed to the betterment of the world and to the actualisation of positive potential in all aspects of life.
- (8) The spiritual person is deeply aware of human pain, suffering, death and the tragic realities of human existence which gives rise to their existential seriousness toward life.
- (9) The spiritual person is one whose spirituality has "borne fruit [e.g., being more peaceful, loving or joyous]" in his or her life and

their spirituality has a discernible effect upon one's relationship to self, others, nature life and whatever one considers to be the Ultimate.

Roberto Assagioli believed that “more than anything else spirituality is concerned with considering life’s problems from a higher, enlightened, synthetic point of view, testing everything on the basis of values, endeavouring to reach the essence of every fact, neither allowing oneself to stop at external appearances nor be taken in by traditionally accepted views, by the way the world at large looks at things, or by our own inclinations, emotions and preconceived ideas” (Assagioli, 1993, p. 213).

Grof (2000) describes two forms of spiritual experience, the *immanent divine* and the *transcendent divine*. It is believed that a person experiencing the *immanent divine* finds their perception of everyday reality profoundly transformed as they realise that the boundaries between people, animals, and inanimate objects in the environment are an illusion. During an experience of the *transcendent divine*, perceptions unavailable in ordinary consciousness seem to “unfold” from another level of reality.

This description by Grof tends to be more indicative of what William James (1902/2007) would classify as a mystical experience rather than a spiritual experience, although the psychological literature does not clearly differentiate the two. Much of the psychological research undertaken in the areas of spiritual experience, religious experience or mystical experience tend to use these words interchangeably, even within the same publication.¹¹

¹¹ It is beyond the scope of this thesis to examine whether or not these terms are examining the same type of experience. For the sake of regularity, the term spiritual experience will be

However, from the literature reviewed for this thesis, the general trend seems to be that research referring to numinous experiences in the west most often call them spiritual experiences, but research referring to numinous experiences from the East, most often call them mystical experiences.

These systems accept mysticism as a form of human experience, they explain the relationship between the mind and the world, the fundamental nature of the world and the Self and recognise that the spiritual dimension is inextricably linked with the physical (Brett, 2002). Brett examined a number of Eastern spiritual systems and extracted a basic structure of the mystical experience:

(1) The attention is turned inward, away from involvement in practical or worldly matters, so that the process of perception itself is the focus of attention.

(2) The thoughts and perceptions that arise are passively experienced, leading to non-identification with these mental events.

(3) The discriminating aspect of the mind perceives that the self as subject is not identical with any mental event, but is an abstraction from pure awareness, which illuminates every mental event.

(4) There is the realisation that the true nature of reality transcends the subject/object dichotomy, that the self is not a discrete entity and has

used throughout this thesis and will include psychological research on spiritual and mystical experiences.

no definitive boundaries against the world, and that the division of the world into entities is a function of the mind.

(5) This existential stance constitutes a radical alteration of the structure of experience, so that the old ontology of the material world in contrast to an independently existing self is unsustainable (Brett, 2002, p.334).

The essence of mystical experience is unity and entire spiritual systems have been built around this concept.¹² The attainment of unity transports the individual far beyond the distinctions necessary for language, logic, and ordinary communication. Although these experiences are known to be ineffable, throughout history a large amount of literature has recorded the experience in great depth. These include such sacred literature as the Tao Te Ching, the Upanishads, the Koran and the books of the Bible (Nelson, 1994). James (1902/2007), a pioneer of psychology, also identified ineffability as one of four characteristics of the mystical experience. The other three include noetic quality, transiency and passivity.¹³

In more recent times, Lukoff, Lu and Turner (1998) acknowledged the variations in definitions of the mystical experience and undertook the task of defining the mystical experience in a way that is both congruent with the theoretical literature as well as holding clinical relevance.

¹² Yogic practice is based on methods promoting the union of human consciousness with universal consciousness.

¹³ James' characteristics of mystical experience are discussed in more detail in Chapter 4.4, Peak Experiences.

The mystical experience is a transient, extraordinary experience marked by feelings of unity, harmonious relationship to the divine and everything in existence, as well as euphoria, sense of noesis (access to the hidden spiritual dimension), loss of ego functioning, alterations in time and space perception, and the sense of lacking control over the event (Lukoff, et al., 1998).

3.2 Introduction to Spiritual Emergence

Throughout history, entire cultures have considered inner transformation an integral part of life. Sophisticated rituals and practices often leading to non-ordinary states of consciousness (or altered states of consciousness) have been formulated to encourage spiritual growth. Such a long history of documented spiritual development may indicate that it is the innate evolutionary capacity of human beings to move toward wholeness or discover their true potential. This inner transformation tends to gradually unfold over months or years and the changes are often so subtle that one doesn't realise that profound shifts in values, ethics and worldview have been made (Grof & Grof, 1991).

Grof and Grof defined spiritual emergence as "the movement of an individual to a more expanded way of being that involves enhanced emotional and psychosomatic health, greater freedom of personal choices, and a sense of deeper connection with other people, nature, and the cosmos" (Grof & Grof, 1991, p. 34). They also expressed the importance that one's increasing awareness in the spiritual dimension plays in the transformational process.

A further definition of spiritual emergence is given by psychiatrist John Nelson who described spiritual emergence as “an awakening into a level of awareness and insight beyond the ordinary capabilities of the ego. It heralds a passage into higher, transpersonal realms of consciousness. Although the self has not yet learned how to manage the power inherent in these breakthroughs, it recognizes them as important signs that guide it on its upward path” (Nelson, 1994, p.264).

The spiritual emergence may briefly and gently present itself in a variety of situations. One may suddenly feel a deeper connection with the environment, experience a number of startling coincidences or be aware of a sense of selflessness or boundlessness, being beyond ego. In some situations the emergence may present itself more dramatically as an out of body experience, an amazing vision or an ecstatic altered state of consciousness that may either momentarily overwhelm the person or inspire a new direction in life (Nelson, 1994).

In order to move into a new expanded way of being it is necessary for the old mode of being or old personality structures to be destroyed. This process has been described as ego death, and often involves an overwhelming feeling that one’s world is collapsing and one’s identity is disintegrating, leaving the person unsure of their place in the world. An individual may experience their physical, emotional and spiritual selves breaking down, lose their identity, or may feel that they are literally dying. During this process, one may lose confidence in their ability to carry out every day tasks and their former interests, ethical stance and friends may no longer hold the same meaning (Grof & Grof, 1991). Whereas some people

may be able to withstand these rapid changes, a 'less prepared' person may be overwhelmed by the influx of new insights and may be thrown into a state of crisis.

3.3 Introduction to Spiritual Emergency

According to Bragdon (1988, pp.21-22), a spiritual emergence is more likely to progress into a crisis when:

- (1) Someone has no conceptual framework to support the experience, with which to understand and accept the phenomenon with equanimity.
- (2) Someone has neither the physical or emotional flexibility to integrate the experience into life.
- (3) The family friends or helping professionals of a person having the experience see the phenomenon in terms of psychopathological symptoms which have no possibility of being positive.

Grof and Grof (1991) have defined Spiritual Emergencies (SEs) as "critical and experientially difficult stages of a profound psychological transformation that involves one's entire being. They take the form of non-ordinary states of consciousness and involve intense emotions, visions, and other sensory changes, and unusual thoughts, as well as physical manifestations" (p. 31).

Physical manifestations may include sensations such as heat or electricity rising up the spine, spontaneous trance states during which the person is unable to move, feelings of tension or pain in the body and facial or body distortion. Spiritual emergencies also include unusual experiences that involve vast changes in consciousness, perceptual, emotional, cognitive, and psychosomatic functioning. They can take on a variety of forms including mythological and archetypal phenomena, memories of what seems to be past life incarnations, out of body experiences, states of mystical union, extrasensory perception, synchronicities, identification with universal consciousness, dramatic death and rebirth sequences and extrasensory perception (Grof & Grof, 1989, 1991).

During the SE the individual may have great difficulty in distinguishing their inner visionary world from the external world of everyday reality. It seems that their logical mind is often bypassed as the colourful, rich world of intuition, inspiration, and imagination takes over. This may bring excitement to some but since it involves non-ordinary states of mind many people believe that they are going crazy. Loneliness also plays a large role during the SE. It can range from the vague perception of separateness from the world and others through to a deep and encompassing alienation. Individuals may require a temporary withdrawal from daily activities as their preoccupation with intense thoughts, feelings and internal processes increases. While Grof and Grof (1991) believe that these states of mind are often intrinsic, necessary, and pivotal parts of the healing process, they can easily become frightening and overpowering, especially when appropriate support is not given.

In some cases it is possible to identify the situation that precipitated the psychospiritual crisis. It may be primarily a physical factor, such as a disease, an accident, or operation that can lower one's psychological resistances by weakening the body. At other times, extreme physical exertion, prolonged lack of sleep, childbirth, miscarriage, or abortion may appear to trigger the crisis. SE can sometimes begin soon after a traumatic emotional experience such as the loss of an important relationship through death or divorce or a loss of employment or financial stability. In other cases, the onset of SE has coincided with exceptionally powerful sexual experiences as well as the use of mind-altering drugs or particularly intense sessions of psychotherapy. Deep involvement in various forms of meditation and spiritual practices such as Buddhist meditation, Kundalini yoga, Sufi exercises, monastic contemplation, or Christian prayer, are some of the most frequent catalysts of SE. It is well known that many spiritual traditions have elaborate systems which have been specifically designed to facilitate spiritual experiences. However, in the west, without the complete understanding of the spiritual teachings, individuals practicing at advanced levels may experience openings too great for them to understand and have no way to integrate them into their worldview, thus moving into a state of crisis (Grof, 2000).

3.4 Introduction to the Sub-types of Spiritual Emergency

The most widely used classification of SE originated with Grof and Grof (1989), who listed 10 categories of SE. These include: (1) The Shamanic crisis, (2) the Awakening of Kundalini, (3) Episodes of Unitive Consciousness or Peak Experiences, (4) Psychological Renewal through Return to the Centre,

(5) the Crisis of Psychic Opening, (6) Past-life Experiences, (7) Communications with Spirit Guides and “Channelling”, (8) Near-death Experiences, (9) Experience of Close Encounters with UFOS and (10) Possession States. These categories are phenomenological descriptions based on reports by people who have encountered an SE and although there is considerable overlap between each of the subtypes there tend to be a greater number of positive and negative characterises which separate them (Grof, 1989).

The SE subtypes used for this research are similar to Grof and Grof’s original classification except that “communication with spirit guides and channelling” was incorporated into the psychic opening category and a further subtype “ the dark night of the soul” was added. The final selection of SE categories used for this research include: the Dark Night of the Soul; The Awakening of Kundalini; The Shamanic Crisis; Peak Experiences; Psychic opening; Past-life Experiences; Near-death Experiences; “Possession” States; Psychological Renewal through the Central Archetype and UFO phenomena. Each of these will be briefly introduced below with a more in-depth investigation in the following chapter.

The Dark Night of the Soul

The “Dark Night of the Soul” has been used as a metaphor to describe a lonely and desolate period of one’s life. The term is derived from the writings of a 16th century Spanish Carmelite monk named St. John of the Cross, a religious reformer imprisoned for his actions. It was during his incarceration that he produced his most famous writings, a poem called “The Dark Night”,

describing the effects taking place within the individual during their spiritual development. St. John illustrates a journey of uncertainty and despair, a passage that needs to be taken in order to cleanse and humble oneself sufficiently to be receptive to Divine inspiration.

According to Grof and Grof (1991) The Dark Night centres on the dissolution of the distinction between the inner and outer worlds and a consequent loss of reference points. Symptoms may involve feelings of struggle, pressure, claustrophobia, oppression, tightness, restlessness or an endless repetition of 'dying' experiences. People often feel as if they are stuck in a meaningless cycle of life where existence can seem flat, arid, and lifeless. As they learn to acknowledge, name and meet each new state with mindfulness, they discover that they are "dying" over and over again, often resulting in a deep and profound desire for freedom. Although this period can be extremely challenging and may be viewed as a negative event, it is believed by many schools of thought to be a necessary stage in the profound experience of inner healing.

The Awakening of Kundalini

'Kundalini' is the Sanskrit word given to what is said to be the dormant potential force which resides at the base of the spinal column in the centre known as *Mooladhara chakra*¹⁴ (Saraswati, 1984). Within the Yogic

¹⁴ A chakra is a major psychic centre in the subtle (astral/psychic) body, responsible for specific physiological and psychic functions. There are myriads of chakras known in the human body but only a few principle ones are utilised. *Mooladhara* is known as the first chakra and is located forward of the base of the spine. *Swadhistana* is the second chakra and is located at the base of the spine. The third chakra is known as *manipurna* and is located in the spinal column at the level of the navel. *Anahata*, the fourth chakra lies in vertebral column behind the base of the heart. The fifth chakra, known as *vishuddhi* lies in the

framework, Kundalini is known as both self and Goddess, representing the creative agent of the Divine, which resides in each living being (Greenwell, 1990) and every atom in the universe (Mookerjee, 1982). This energy is said to lie dormant in many people throughout their entire lifetime. It is the objective of Kundalini yoga to awaken this energy and unite it with what is known as “Pure Consciousness”, the fundamental reality said to underlie all objects and experiences which pervades the entire universe (Mookerjee, 1982). Although Yogis seek the awakening of Kundalini, if it is awakened in a body and mind that is not ready for the huge influx of energy it can lead to a state of crisis.

The Shamanic Crisis

The roots of Shamanism can be traced back to the Palaeolithic era, existing approximately thirty or forty thousand years ago, and represents the most widespread and ancient methodical system of mind-body healing known to humanity (Harner, 1990). Evidence of a Shamanic culture can be found on the walls of caves in southern France and northern Spain, which are decorated with images of animals representing species that roamed the Stone Age landscape (Grof & Grof, 1991).

Shamanism has been defined as a family of traditions whose practitioners focus on entering altered states of consciousness where they travel to other realms and interact with other entities in order to learn, acquire power, heal and serve their community (Walsh, 1989). The Shaman has

vertebral column at the level of the throat pit. *Ajna* is the sixth chakra and corresponds to the pineal gland directly above the spinal column. There are also two higher chakras, *bindu* which is located at the back of the head and *sahasrara*, the crown chakra located at the top of the head (Saraswati, 1984).

mastered the ability to move in and out of non-ordinary states of consciousness at will, and with the help of benevolent spirits they receive visions and insights conducive to healing. Shamans often begin their journey with a dramatic involuntary visionary episode called a “shamanic illness”, where they lose contact with their environment and encounter a series of terrifying and ecstatic experiences. As the Shamanic journey is a universal phenomenon, people in non-shamanic cultures can also experience similar episodes. If one has no context in which to place these experiences, one may become frightened, fear their sanity and fall into a state of psychospiritual crisis (Grof & Grof, 1989, 1991).

Peak Experiences

Abraham Maslow, one of the founders of humanistic and transpersonal psychology, believed that a good theory of personality needed to examine not only the depths but also the heights of human experience. He developed the hierarchy of needs, indicating that individuals must satisfy their basic physiological, safety and security needs before they can explore their psychological needs for love, belonging and esteem. Once these needs have been satisfied the individual is then able to grow toward what he believed to be the intrinsic state of self-actualisation, the state of being all that one can be.

Maslow (1986) proposed that the self-actualised person is more likely to experience great levels of happiness, harmony and fulfilment. He coined the term “peak experience” to describe this state of being and acknowledged that experience in the peak state lies beyond the usual levels of meaningfulness, intensity and richness of everyday experience. Maslow

believed that the peak experience shared similar characteristics with the mystical experiences and spiritual awakenings as described throughout history by the mystics. If the peak experience occurs in an individual with no framework that allows them to understand their experience they may be thrown into a state of spiritual emergency.

Psychic Opening

Throughout history, a number of spiritual traditions have described paths and practices that if followed improve one's mental and physical health. Some traditions pursue a meditative approach, involving practices to help quiet the mind and it is said that once the mind is quiet, one is more likely to experience the emergence of psychic images or perceptions.

During this period of psychic opening individuals often acquire information that could not be obtained through conventional means. For example, they may experience episodes of telepathy, out-of-body experiences, precognition, clairvoyance or a string of synchronicities.¹⁵ Fascination and obsession with these phenomena are not only seen as an obstacle in the pursuit of genuine spiritual experience but also as a trap for the seeker's ego. If the seeker can let go of these experiences, they may be able to integrate their higher levels of intuition and psychic abilities into their new worldview. However, occasionally this influx of information from non-ordinary sources becomes frightening and overwhelming as it challenges one's understanding of reality. This may throw the individual into a state of

¹⁵ These types of psychic opening will be described in detail in Chapter 4.5.

fear, confusion or panic and cause them to question their sanity (Grof & Grof, 1991).

Past-life Experiences

There have been numerous reports from individuals around the world experiencing what they believe to be recollections of a past life. These recollections often involve powerful emotions surrounding sequences of events, portraying the personal circumstances and experiences of an individual taking place in other countries and/or different historical periods (Grof & Grof, 1989, 1991). These narratives often occur in great detail, and in many cases the experiencer is convinced that these events are personal memories from a previous lifetime. It has been suggested that past-life experiences (PLEs) may be able to provide an explanation for puzzling behaviours, experiences or peculiar aspects of an individual's life, such as untenable fears and phobias (Mills & Lynn, 2000).

It is believed that although we do not generally recall events from past lives, on occasion isolated incidents can emerge into consciousness. When this material emerges in the midst of everyday activities it can lead to serious emotional and physical distress and interfere with normal functioning. Whether or not these experiences are indicative of a past life or give weight to a reincarnation hypothesis, Grof and Grof (1989; 1991) believe that if investigated further, these experiences may hold great potential for healing.

Near-death Experiences

Throughout history there have been numerous recorded accounts of experiences associated with death and dying. These range from folklore and world mythology—for example the writings of Plato (428-348 BC) and Emanuel Swedenborg (1688-1772)—to detailed sacred texts such as *The Tibetan Book of the Dead*, which describes the moment of death and maps out the states that lie immediately beyond. Until recently, much of this was discounted by western science as the product of fantasy and imagination of primitive people (Grof & Grof, 1989).

It was not until Elisabeth Kubler-Ross' (1975) research into death and dying and Raymond Moody's (1975) seminal work on near-death experiences (NDEs) that this field became a legitimate area of scientific inquiry. Moody's initial investigations revealed that individuals from various cultural groups, social and religious backgrounds reported similar experiences when facing death. It was based on these findings that Moody identified a common set of elements, which he proposed constituted an NDE.

This research has indicated that the process of dying can be associated with an extraordinary inner journey into the transpersonal regions of the psyche. However, NDEs often lead to a state of psychospiritual crisis as they fundamentally challenge the experiencer's concept of reality (Grof & Grof, 1989, 1991).

“Possession” States

The concept of “spirit possession” has existed throughout history in the folklore and mythology of many cultures. Contemporary examples of “possession” still exist worldwide and are generally found in communities where indigenous traditions have been maintained (Keller, 2002). “Spirit possession” has also held an important role in historical religious traditions where the deliberate induction of “possession” states has been an integral part of religious ceremonies. Rituals focussing on the “possession” state have been documented in ancient Egypt and ancient Greece and it continues to play a central role in present day Haitian voodoo ceremonies as well as Balinese ritual drama.

In some contemporary forms of evangelical Christianity it is considered desirable to be possessed by the Holy Spirit, which manifests in shaking of the body and “speaking in tongues” (Lukoff, 2007). In fact Lewis (1995) has found that every major religious and cultural tradition worldwide has espoused the idea of spirit possession and the need for some form of exorcism.

“Possession” can cause a broad spectrum of problems and at times is believed to be the hidden force behind mental illness. In some cases a “possessed” individual may be aware of the emerging energy and spend vast amounts of effort trying to control it. If these defence mechanisms fail, and the “possessed” individual cannot control the energy, it may manifest in the midst of everyday life and lead to highly destructive forms of psychopathology (Grof & Grof, 1989, 1991).

Psychological Renewal through the Central Archetype

It is believed that archetypal images are primordial patterns and form the basic content of religions, mythologies, legends and fairy tales of all ages. Archetypes are perceived and experienced subjectively through these universal mythological motifs and images as well as emerging from the collective unconscious. These images can arise in dreams and visions, during times of deep psychological analysis, profound subjective experience or during episodes of mental illness. An encounter with archetypal images has a strong emotional impact, conveying a sense of divine power, which transcends the individual ego and often leaves the individual in a state of transformation (Edinger, 1968).

The archetype representing the centre, the central archetype or the Self, expresses psychic wholeness and totality. During the activation of this archetype there is a flooding of dramatic, disturbing and ecstatic imagery into the conscious awareness of the individual. The initial part of this process is often chaotic and confusing but when it is allowed to proceed through this stage, the experiences gradually move toward healing and restoration (Perry, 1999).

Throughout his work with individuals in non-ordinary states of consciousness, Perry (1999) found a predictable pattern of imagery that he termed the “renewal process”. Perry also proposed that this process represents movement toward a fuller expression of one’s deeper potential, also known as “individuation” (Grof & Grof, 1991).

UFO Phenomena

Much of the recorded documentation about UFOs focuses on the alleged sightings of extraterrestrial beings or spacecraft, discussions about whether or not they are real, and, if so, where they are from and what they want. There are also growing numbers of reports from people who claim to have been abducted by an alien and to have experienced a series of events aboard some kind of alien spacecraft.

Even though many people have reported being abducted by aliens, it is difficult for many people to take their reports seriously. John Mack (1992a), late Professor of Psychiatry at Harvard Medical School, believed that the stories we hear are so bizarre or impossible to understand from the viewpoint of the worldview in which we live that our minds cannot accept them as real. This thesis is not concerned about whether UFOs, aliens or the physical experience of abduction are objectively true. It simply attempts to provide an overview of various theories of UFO phenomena and the psychological implications for experiencers.

3.5 The Healing Potential of Spiritual Emergency

During the psychospiritual crisis vast amounts of psychological material becomes available from the unconscious, which can often interfere with the everyday functioning of the individual. Because the content of these inner experiences appear to be out of context with everyday reality, they can become frightening and confusing and may be associated with pathology.

However, these emotional and psychosomatic symptoms can also be indicative of a healing effort by the organism and a movement toward a higher level of consciousness evolution. If the process is supported and the person is able to completely experience the material emerging into consciousness, the process can lose its power and psychological and physical healing can take place. For this to occur it is important to give the person in crisis a positive context for their experience and move away from the model of disease to recognise the inherent healing power of the process (Grof & Grof, 1989, 1991). Bragdon (1988) believes that it is important for the individual to be able to integrate their experience into their self concept and life in order to obtain the full healing potential of the experience (Bragdon, 1988).

Successful completion and integration of the SE has been associated with reduced aggression, an increase in racial, political, and religious tolerance, ecological awareness, physical and emotional healing, an increase in creativity, positive changes in personality, profound insights into one's life and values as well as positive changes in personality (Grof, 2000).

With a vast capacity for growth, it is unfortunate that most psychiatrists are not aware of the various psychospiritual crises and if faced with one, would not be able to differentiate it from a psychotic episode. However, a growing number of psychiatrists have recognised that some psychotic episodes have the potential for positive outcomes and have developed new categories for them. These include mystical experience with psychotic features (Lukoff, 1985), nadir experiences (Maslow, 1986), positive disintegration (Dabrowski, 1964) and the renewal process (Perry, 1999) to name a few.

Given that recent surveys in Britain, America and Australia have reported that approximately one third of the population have encountered some type of spiritual experience, it is of great importance that medical professionals be able to distinguish between these and psychopathology (Argyle, 2000).

3.6 Conclusion

During an episode of SE one may experience various phenomena such as an out of body experience, sequences of psychological death and rebirth, visions or visits to mythological realms of various cultures, past incarnation memories, a string of coincidences or various forms of extrasensory perception. Episodes of this nature can be found throughout history in the stories of shamans, yogis, the mystics and saints. Within the mystical literature, these crises are described as important signposts of the spiritual path and confirm their healing and transformative potential (Grof, 2000)

In more recent times these episodes have been considered natural and normal manifestations of the deeper dynamics of the human psyche (Grof & Grof, 1989, 1991; Grof, 1993, 2000; Perry, 1999). Grof (2000, 2001) has suggested that it is due to the narrow conceptual framework of western psychiatry that limits the mainstream psychiatrist's ability to determine the difference between mystical states or psychospiritual crisis and psychopathology. If attempts are made to interpret these states within the narrow model of the psyche currently employed by psychiatry, it risks pathologising the entire spiritual history of humanity and thus labelling the

founders of great religions, saints, shamans and prophets, who had great visionary experiences, as psychotics, hysterics, epileptics or schizophrenics. This stance also assumes the position that only the western civilisation that subscribes to the monistic materialism of western science has an accurate understanding of existence (Grof, 2000, 2001)

CHAPTER 4: SUB-TYPES OF SPIRITUAL EMERGENCY

4.1: THE DARK NIGHT OF THE SOUL

“You cannot find the Light unless you enter the darkness.”

An ancient mythical insight

4.1.1 General Introduction

The “Dark Night of the Soul” has been used as a metaphor to describe a lonely and desolate period of one’s life. The term is derived from the writings of a 16th century Spanish Carmelite monk named John of the Cross (Kavanaugh & Rodriguez, 1991), a religious reformer imprisoned for his actions. It was during his incarceration that he produced his most famous writings, a poem called “The Dark Night”, describing the effects taking place within the individual during their spiritual development. John of the Cross illustrates a journey of uncertainty and despair, a passage that needs to be taken in order to cleanse and humble oneself sufficiently to be receptive to what is perceived to be Divine inspiration.

Like St. John, it is said that St. Teresa of Avila (1515 - 1582), a 16th century Spanish saint and mystic also encountered a long period of interior darkness filled with loneliness and abandonment. Teresa experienced a prolonged sickness for 18 years during which she increasingly encountered exotic mystical experiences such as visions, raptures, and spiritual ecstasies. Teresa detailed her spiritual journey of prayer in seven stages using the

metaphor of progressively moving from the outermost room of the interior castle of the soul through to the 7th and innermost room in which one attains union with God (Kavanaugh & Rodriguez, 1991).

According to Grof and Grof (1991) the Dark Night centres on the dissolution of the distinction between the inner and outer worlds, and a consequent loss of reference points. Symptoms may involve feelings of struggle, pressure, claustrophobia, oppression, tightness, restlessness or an endless repetition of 'dying' experiences. People often feel as if they are stuck in a meaningless cycle of life where existence can seem flat, arid, and lifeless. As they learn to acknowledge, name and meet each new state with mindfulness, they discover that they are "dying" over and over again, often resulting in a deep and profound desire for freedom. Although this period can be extremely challenging and may be viewed as a negative event, it is believed by many schools of thought to be a necessary stage in the profound experience of inner healing.

4.1.2 The Dark Night of the Soul

John of the Cross described the Dark Night as a stage in one's spiritual journey where the initial period of grace becomes replaced with a long and painful loss of connection with the perceived Divine. He believed that the Dark Night prepares one to live in accordance with the great mysteries, to be an inherently spiritual individual deeply participating in all aspects of one's life. John explains that just as the night comes on at dusk and gets darker during the middle hours to give way at dawn, so follows the path of one's spirituality and connection with the Divine (Kavanaugh & Rodriguez, 1991).

John describes the dark night in two phases. First, after the most splendid illumination resulting from contemplative spiritual practice or deep contemplative prayer, one enters a dry and barren place, the “Dark Night of the Senses”. This is a time of profound loss, where everything that has previously provided comfort and support loses its meaning. Here, one purifies oneself of pride, greed and anger, and deepens one’s understanding of the sorrows caused by separation from the perceived Divine (Kavanaugh & Rodriguez, 1991; Kornfield, 2001).

The second and darkest period is the “Dark Night of the Spirit”, which is commonly referred to as “The Dark Night of The Soul”. This is a stage of great suffering, grief and confusion, where further purification and surrender is required (Kornfield, 2001). Here, one of the greatest miseries is the apparent loss of the power of contemplation or prayer. Where there was once understanding and comfort there is now helplessness, emptiness, and loneliness. However, it is through this process that one comes to know the content of their heart and mind, confronting their fears and beliefs while consciously pursuing their shadow side, or unowned aspects of one’s personality (Kavanaugh & Rodriguez, 1991; Myss, 1996). It is through this process of stripping away that a passionate love and longing for the Divine arises (Kornfield, 2001).

Although John acknowledges the great amount of suffering that takes place during the Dark Night, he explains that it is the darkness which helps us to find what we are searching for, not the light at the end of the darkness. He indicates that the Dark Night is a necessary stage of the spiritual journey and speaks of the unutterable sweetness, which is the great reward awaiting those

who persevere and honour the soul's dark nights (Kavanaugh & Rodriguez, 1991; Kornfield, 2001).

Grof and Grof (1991) believe that the Dark Night not only arises during a period of one's spiritual development, but it can also arise as the result of particular circumstances in life which challenge the individual's sense of identity or self-image. Such circumstances might include physical or mental illness, death, divorce or separation, loss of job security, or an existential crisis.

According to May (2004), the Dark Night is not a one-off occurrence, but an ongoing transition where the individual moves from a tightly controlled life toward one with more trust and openness with the Divine. It is not a continuous time of suffering, it has its peaks and valleys, and the process moves at its own pace with no predictable order of experiences. May believes that the Dark Night is a process similar to the trials and tribulations experienced by all during some stage in their life. Here it is plain to see how the concept and understanding of the Dark Night has changed from its original emphasis on the mystical journey and the transition to higher mystical contemplation and connection with the Divine, towards a more psychologically based understanding.

4.1.3 Models of the Dark Night of the Soul

According to Underhill (1960), the Dark Night is a state of disharmony, an imperfect adaptation to the environment. Underhill explains the psychological dimensions of the Dark Night as both a period of exhaustion of an old state of being as well as the individual's growth towards a new state of

consciousness. During the transition period, individuals lose control over their spiritual life as well as over their worldly responsibilities. They are tormented by evil thoughts and unexpected temptations and things seem to “go wrong” in all areas of their life. The individual’s physical health suffers, they become distant from their friends and their intellectual capabilities diminish.

This period of confusion and misery can last for months or even years, before one’s consciousness reaches its new state. During the crucial movement toward its new state, the ‘self’ continually parts with unnecessary and outgrown elements. Even though the ‘self’ hasn’t reached a point where it is ready to enter into the new state of consciousness, it feels a continual push towards its new state. On these grounds Underhill sees the Dark Night as essentially a “growing pain”, an intrinsic movement toward completeness.

As well as the psychological aspect, the Dark Night also has a mystical or transcendental aspect. From this perspective the Dark Night can be seen as a cathartic process of the senses and the spirit.¹⁶ The self, usually immersed in the illusion of the senses, has glimpsed reality and transcended the normal perceptive powers of “natural” man (Underhill, 1960). Mystics consider all forms of the Dark Night to constitute the final “purification of the will”, the merging with the Absolute. The purification of the will is the struggle to resolve the disharmony caused by the perceived separation of the soul from the Divine. This is a deeply human process, in which the self, once thought to be so spiritual and so firmly established, is forced to turn back, to leave the Light, and pick up those qualities, which it had left behind.

¹⁶ Spirit is defined as “the vital principle or animating force within living things” (Dictionary.com, 2007; Retrieved May 28, 2007, from: <http://dictionary.reference.com/browse/SPIRIT>)

The dark night has been linked with the mid life crisis. Washburn (1988) believes that the dark night shares similar features to the mid life crisis. He explains that during the first part of life when we are developing our egos and establishing ourselves in the world, we typically have an outward focus and turn our back on some essential resources of the deep psyche such as our emotional life, creative potential and our spirituality. Washburn calls these resources, or potential energies, the dynamic ground.

In later life, if we suffer a profound disillusionment, questioning our very existence, we may find ourselves turning back towards the resources we have repressed in our earlier formative years. Here, the ego turns back to face the dynamic ground, and begins the spiraling and difficult "regression in the service of transcendence", which Washburn equates with the dark night of the soul (Washburn, 1988; see also Jung, 1960a). In this way, the Dark Night is something that can affect us all, not just those who are striving for spiritual understanding.

4.1.4 The Dark Night of the Soul and Psychopathology

Although many individuals experiencing the Dark Night are able to successfully participate in their daily activities, May (1982) believes that a lack of understanding and support throughout their experience could develop into a crisis of faith and possibly lead to depression. May has revealed a number of similarities between reactions to the Dark Night and depression, including feelings of hopelessness, helplessness, agitation, emptiness, impoverishment of thoughts, absence of motivation and a loss of self-confidence.

Grof and Grof (1991) also indicated that feelings of loneliness, loss of energy, loss of control over direction in life, loss of identity, frustration, withdrawal from everyday routines, feelings of madness and insanity, feelings of inadequacy, lessened feelings of attachment to family and friends are common to both depression and the Dark Night. According to O'Connor (2002), the major similarity between the Dark Night and depression is loss. During the Dark Night the loss concerns the individual's relationship with the Divine whereas the depressed individual usually suffers a loss of a more secular nature, which may in turn precipitate a loss in life's meaning.

According to May (1982), there are also a number of major differences between the Dark Night and depression. A depressed person may lose their sense of humour, or they may become cynical or bitter, whereas this is not usual during the Dark Night. Compassion for others tends to grow after a Dark Night experience, in contrast to the depressed person, who may remain self-absorbed. Depressed individuals may plead for help, whereas during the Dark Night one is more likely to seek an explanation or evaluation of their experience. The depressed individual is often unable to carry on effectively with their daily activities or work whereas an individual experiencing the Dark Night is often perplexed at how well they continue to function. During the Dark Night there may be great dissatisfaction and confusion, but there is also an underlying sense that everything is "all right" the way it is, whereas a depressed individual feels a deep sense of "wrongness" and a strong desire for change. May believes that one of the most subtle and important differences is that one is much more likely to feel consoled with someone experiencing the Dark Night in contrast to feeling frustrated, resentful or annoyed in the presence of depressed

individuals. Finally, Grof and Grof (1991) believe that the major difference between the Dark Night and depression is that the Dark Night is an inner experience between the individual and God during which a deep and rich spiritual growth is unfolding.

Individuals experiencing the Dark Night and those experiencing depression share a number of common symptoms, which may occur simultaneously or which may mask each other. But, they also have a number of unique features, which require different understanding and different responses in order to achieve the best possible outcomes for the individual (O'Connor, 2002).

4.1.5 The Dark Night of the Soul as Spiritual Emergency

The Dark Night includes a number of components considered by Grof and Grof (1991) to constitute a spiritual emergency. These consist of various fears including fear of the unknown, fear of what experiences lie ahead, and the fear of losing control. The individual may participate in isolating behaviour by being drawn into activities that require one to be alone or to activities that others don't understand. During a crisis of this kind, the individual feels cut off from their deeper self, higher power, or God, which results in an overwhelming sense of loneliness, a total and complete alienation penetrating their entire being. While Grof and Grof (1991) believe that these states of mind are essential parts of the healing process, when support and understanding are lacking these states can become even more frightening or overwhelming, resulting in further fear that the person may be losing control of their minds.

Myss (1996) believes that the three strongest symptoms indicating that one has entered into the Dark Night include the absence of meaning and purpose, the fear of losing touch with a sense of self or self-identity, and the need to experience devotion to something greater than oneself. These characteristics are somewhat similar to common psychological dilemmas experienced by many individuals, but their root is spiritual and the individual realises that the cause of the crisis is within. The external condition of the individual's life is a consequence of the crisis within, and no amount of reshuffling things on the outside will "fix" it.

Many individuals experiencing the Dark Night develop a preoccupation with death, which Grof and Grof (1991) believe is a pivotal point in the transformational process. They claim that it's necessary for the old self-limiting mode of existence to 'die', for the ego to be destroyed, before a new self or a larger self-definition can become available. This process is part of a continuous death-rebirth cycle, which once understood, releases the individual from the fear of death, and opens one to the subjective experience of immortality. The Grofs propose that many traditions contain the notion of "dying before dying" as a tremendously liberating, essential component of spiritual advancement.

Myss (1996) claims that a profound change in one's worldview always contains a period of isolation and loneliness until one becomes familiar with their new level of understanding. This holds true for individuals experiencing the Dark Night. In fact Grof and Grof (1991) have found that some individuals experience a quick resolution and a smooth transition into their new way of

being, while others experience a re-entry period, a time when they are unsure of themselves and their place in the world.

4.1.6 Summary

The concept of the Dark Night has most often been associated with mystical and spiritual seekers in the west. However, as a metaphoric representation of the inner process taking place on the way to the innermost part of one's being, the experience could potentially occur to anyone regardless of race. Whether the experience is labeled a Dark Night, a nervous breakdown, an existential crisis or a psychotic episode, is in part determined by the individual's personal or cultural interpretation of the process.

However it is interpreted, this metaphoric journey essentially describes a dark and difficult part in one's psychospiritual journey. It is believed that the Dark Night delves into the hidden areas of our being and brings our ego-based imperfections to the surface, where their presence can be acknowledged and the imperfections stripped away to leave the individual in the presence of their Divine nature. Although this is ultimately seen as a necessary cleansing process, it can be a demanding and challenging experience, possibly leaving one in a state of emotional upheaval. If this inner process can be understood as beneficial for the individual, and the individual is supported during this process, it is believed that it may lead to a most profound experience of psychological and spiritual healing.

4.2: THE AWAKENING OF KUNDALINI

4.2.1 Introduction to Kundalini

The word Kundalini is derived from “*kunda*”, meaning “a deeper place, pit or cavity”, the same name given to the fire pit used in certain initiation ceremonies, as well as the cavity in which the brain sits (Saraswati, 1984). However, the most common translation comes from the Sanskrit “*kunda*” referring to a coil (Saraswati, 1984), so in yogic literature, Kundalini is most often represented as a sleeping serpent coiled three and a half times around the central axis at the base of the spine (Mookerjee, 1982).

Kundalini is considered to be part of a subtle energy system, which has been acknowledged by various cultures for thousands of years. Extensive research by Motoyama (1972, 1975a,b, 1976, 1978, 1979, 1980, 1981, 1982; cited in Saraswati, 1984) has revealed what many believe to be electro-physical evidence for the existence of this subtle energy system, which maps out the *chakras* and the *nadis*¹⁷, forming its infrastructure. In the Yogic context, chakras, literally meaning “wheels” or “circles”, are seen as vortices of psychic energy, which are visualised and felt as circular movements of energy at particular rates of vibration along the spinal axis within the subtle body (Saraswati, 1984). It is considered that each chakra has its own neurological plexus and endocrine gland and links up to various organs and systems in the body. Yogic philosophy also believe these organs and systems to be connected to the controlling mechanisms of the brain, each of which has emotional, mental and psychic components (Saraswati, 1984).

¹⁷ A psychic channel for the distribution of prana in the astral (subtle) body (Saraswati, 1984).

When aroused, it is claimed that Kundalini generally travels from the *Mooladhara* chakra, at the base of the spine, upwards along the spinal cord, passing through each of the psychic centres on the way to the crown chakra. Here it is believed to stimulate a dormant chamber of the brain known as the *Brahma randrha* which charges each cell in the body with *prana*¹⁸ and speeds up the process of one's physical, mental and spiritual 'evolution'. With the awakening of Kundalini, it is said that one's perspective changes, one's awareness broadens, and one is able to gain a deeper understanding of nature and the cosmos. It is also claimed that the full awakening of Kundalini is the peak of human evolution, the absolute and final state attainable by human beings, the experience in which one becomes an "embodiment of divinity" (Saraswati, 1984).

4.2.2 The Kundalini Experience

Gopi Krishna has written and spoken extensively about the "evolutionary" potential of the awakening of Kundalini from the viewpoint of his own personal experience. In an interview with Kay (2007), Krishna speaks of the so-called *Brahma randrha*, or the cavity of Brahman. He believes that when this is activated by Kundalini, the individual experiences the same vision of the universe that many great mystics have described throughout history. According to Krishna (1971) the human brain is still evolving and nature has provided the potential to awaken this part of the brain to enable human consciousness to transcend its normal limits of highest intellect. This, he says, is the final phase of the present evolutionary impulse in human beings.

¹⁸ The life force or vital energy in the body (Saraswati, 1984).

Various cultures have developed ways and means to attain these higher realms of consciousness. For example, the practice of Taoist yoga includes a process similar to awakening of Kundalini known as the “opening of the microcosmic orbit” (Lu, 1970). In this model there are four cardinal points through which this energy travels: one below the base of the spine, where the generative force is gathered, another at the top of the head, with two more points between them, one along the spine, and one near the chest. Sanella (1997) uncovered a cycle similar to the microcosmic orbit during his clinical investigations of individuals who have experienced Kundalini awakenings. He reported that the physical sensations travelled up the legs, along the spinal column to the top of the head and then continued down the face, through the throat and terminated in the abdomen.

Sanella (1997) explains how the experience of Kundalini awakening falls outside the categories of both ‘normal’ and ‘psychotic’ experience. He believes that the awakening of Kundalini is twofold process of mental *and* physiological purification, leading to a healthier and more developed state than what we would generally consider normal. The individual undergoing the transformation allegedly has mental, physical and spiritual experiences well beyond those we would consider normal, usually without becoming so disorganised as to be considered psychotic. Saraswati (1984) believes that it is the real yogi or swami who can freely move through these states at will, depending on the degree of his skill and mastery.

The Jungian perspective on the awakening of Kundalini focuses on the psycho-spiritual aspects of the experience. Jung theorised about subtle

anatomy,¹⁹ including the awakening of Kundalini, as aspects of the unconscious mind, as well as symbolic representations of the human psyche (Speligman & Vasavada, 1987). Halligan (1992), a Jungian psychologist, describes the rising of Kundalini to the crown chakra, as an alchemical conjunction, the mystical marriage of opposites occurring in any spiritual journey which makes union with the divine a subjective reality. Therefore many Jungians believe that Kundalini is the eastern version of individuation, the process of integrating elements of the unconscious and conscious mind, thereby becoming a psychologically whole individual.

In contrast to Jung, Bentov (1977) has proposed a physiological model of Kundalini. He believes that in given favourable circumstances, the normal “evolution” of the human nervous system can be accelerated. He considered that this is caused by bio-rhythmical pressure waves which result from the interaction of the heart beat, breathing, and the fluid inside the skull, thereby causing the brain to oscillate up and down, stimulating specific nerve centres in the brain. This triggers a predictable sequence of physiological stresses within the body that he described as the progressive sensory-motor cortex syndrome. While Bentov acknowledged that the concept of Kundalini involves spiritual forces and effects beyond these physiological symptoms, he proposed this limited mechanical-physiological portion of the Kundalini syndrome as a useful working model to further investigate the phenomenon.

¹⁹ The psychic or astral body believed to co-exist with the physical body (Saraswati, 1984).

4.2.3 The Awakening of Kundalini

In classical descriptions of Kundalini awakening, the latent energy residing at the base of the spine in the form of a coiled snake uncoils and shoots up through *sushumna nadi* (a channel within the central nervous system), through each of the chakras until it reaches the brain (Saraswati, 1984). During its rise, Kundalini encounters blockages, where it is said to engage in a self-directed, self-limited process of removing or cleansing each one before moving on to the next. Kundalini continues its upward journey of purification or balancing until all the blockages have been removed (Sanella, 1997) and the corresponding dormant areas within the brain have been activated (Saraswati, 1984). Once awakened, this powerful, primal energy moves with intention throughout the body and psyche, where it is believed to have the ability to transform the body at a cellular level (Greenwell, 1990). Note that there are different schools of thought on the procedure. Chinmoy (1974) advises that the initiate start at the fourth (heart) chakra, which is safer, and work from there because the base chakra is too dangerous to work with for the novice who is not familiar with the process, or not strong enough to handle Kundalini energies.

This transformational process is always accompanied by varying degrees of physical and psychological signs and symptoms, and Greenwell (1990) has classified these phenomena into seven primary categories.

The first category, pranic movements or *kriyas*, consists of intense, involuntary body movements, shaking, vibrations, jerking, sensations of electricity, tingling, and waves of energy throughout the body.

Category two, physiological problems, includes the emergence of latent illness or pseudo-illness, heart problems, gastrointestinal disorders, nervous problems, eating disorders, and pains occurring in various parts of the body, especially along the spine and in the head as well as internal sensations of heat, burning, itching, high sensitivity, hyperactivity, lethargy and extreme variations in sexual desire.

The third category consists of yogic phenomena where the body or the hands may involuntarily perform postures or hand movements and the psyche may produce geometrical images, chants, words or sounds, many of these unknown to the experiencer.

Category four includes psychological upheavals such as the intensification of unresolved psychological issues, fear of death or insanity, mood swings, and waves of anxiety, anger, guilt, or depression as well as profound compassion, unconditional love, and heightened sensitivity to the moods of others.

The parapsychological experiences category consists of such phenomena as precognition, healing abilities, reading the minds of others, unusual synchronicities, electrical sensitivity and psychokinesis.

The extrasensory experiences category, which is often identified as a subcategory of the parapsychological, includes atypical perceptions such as lights, symbols, images of entities, the reviewing of other lives, visions, auditory input including voices, music, repeated phrases or continual inner sound and olfactory sensations.

The final category, *samadhi* or *satori* experiences, includes sensations of deep peace, wisdom, experiences of light, tranquillity, joy, overwhelming

waves of bliss and the absorption of consciousness into a condition of unitive awareness.

Greenwell (1990) acknowledges that each individual demonstrates a unique pattern, varying in intensity and duration, and suggests that when one's experiences fall into several of these categories this indicates a high probability of Kundalini awakening.

Sanella (1997) believes that the signs and symptoms, such as alterations in emotions and thought processes, visions and voices all appear to be largely personality determined. But sensations such as itching, fluttering, tingling, heat and cold, perceptions of inner lights, sounds and the occurrence of contortions and spasms appear to be quite universal. He proposes that this universality may indicate that all spiritual practices are activating the same basic process and that these processes may have a definite physiological basis that gives rise to these specific bodily symptoms.

Saraswati (1984) focuses on the changes that take place in the mind during the awakening of Kundalini. When this happens, one transcends the normal categories of mental awareness, the scope of one's knowledge becomes greater, the mind becomes dynamic, while the quality and experiences of the mind begin to change. When one looks at people, animals, and nature, there is a deeper communication with them, a realisation of some inner essence. Matter appears to lose substance, one's body may feel like it is made of air or one may feel that they are no longer a part of their physical body.

4.2.4 Kundalini Awakening and Psychopathology

According to Gopi Krishna (1975), it is acknowledged in India (and somewhat known in the west), that Hatha Yoga²⁰ practices can lead to mental illness. It is said that only those who are prepared to face death, take on the extreme disciplines of Hatha Yoga. However, Saraswati (1984) informs us that the awakening of Kundalini can occur without incident, but if the individual does not understand how to relate to the activation and circulation of Kundalini it may result in serious physical or mental crises. It is for this reason that many Eastern traditions emphasise that if one has the intention of awakening Kundalini, it is important to undertake rigorous training with a knowledgeable teacher.

Sanella (1997) believes that disturbances caused by Kundalini are not pathological and do not lead to psychosis in healthy individuals. But a person with a sensitive nervous system or one receiving negative feedback from social pressure, could develop a schizophrenic-like condition. Greenwell (1990) also disagrees that the awakening of Kundalini leads to psychosis, but suggests that the spontaneous awakening of Kundalini in individuals exhibiting borderline or narcissistic features can lead to major difficulties with ego identity and spiritual integration resulting in psychotic-like behaviour. She also suggests that spiritual themes arising during a psychotic episode are not indicative of the awakening of Kundalini and that weak ego boundaries may activate physiological symptoms similar to those of Kundalini awakening, which may lead to confusion between the two.

²⁰ A system of yoga emphasising practices to purify the body.

Greyson (1993) has summarised a number of Kundalini phenomena (K), which resemble the symptoms of schizophrenia (S). These include: hearing internal voices (K) or auditory hallucinations (S), becoming locked into unusual positions (K) or catatonic rigidity (S), sudden, intense mood swings for no reason (K) or inappropriate affect (S) one's thoughts speeding up or slowing down (K) or formal thought disorder (S). He has also outlined an extensive list of Kundalini phenomena, which are not characteristic of schizophrenia, as well as a further list of typical schizophrenic phenomena, which are not characteristic of Kundalini awakenings. Greyson explains that although there are some similarities, there is actually little overlap between the two conditions, if the entire range of symptoms is taken into account.

Further research by Greyson (1993) did not support anecdotal suggestions that Kundalini phenomena are common in mental illness or that large numbers of institutionalised psychiatric patients suffer from misdiagnosed Kundalini awakenings. However, that doesn't rule out the possibility that mental health workers, most of whom would not be familiar with the phenomenon, may misdiagnose Kundalini-like phenomena as symptoms of mental illness.

Finally, the process of Kundalini awakening has also been dismissed as a psychosomatic or neurotic disturbance, as the symptoms are of variable duration with some of them lingering for months or years (Mookerjee, 1982). However, Saraswati (1984) advises that the awakening of Kundalini should never be equated with abnormal psychological behaviour, because awakening of Kundalini is a process of "jumping out of the mind" or beyond the limitations of the mind.

4.2.5 Kundalini Awakening as Spiritual Emergency

Saraswati (1984) believes that adequate preparation on the physical, mental and emotional planes is essential to ensure that one has the strength to bear the full impact of Kundalini awakening. With an increase of Westerners interested in yoga, purposefully awakening their Kundalini with inadequate preparation or without the guidance of an awakened teacher, it is not surprising that many individuals find themselves plunged into a state of chaos. It is when one is thrown into this state of crisis that the awakening of Kundalini can become a spiritual emergency. Greenwell (1990) believes that if these individuals have no context with which to understand the process, and if they are misdiagnosed or treated with psychotropic drugs, they may indeed develop a serious mental illness.

When investigating the awakening of Kundalini, the Hindu belief that consciousness is not the finished product of nature, but is subject to evolutionary processes must be taken into consideration. It is the aim of Kundalini yoga to bring the power of the unconscious or higher consciousness into normal consciousness. It is believed that ordinary consciousness and transcendental consciousness cannot be maintained at the same time. Given this premise it is thought that one must pass through an intermediate zone of change where perceptions, feelings and experiences undergo a drastic transformation. In the yogic tradition it is believed that between one state of being and the next there is a crisis and when unusual symptoms occur in an individual it is believed that his or her consciousness is undergoing this so-called evolution (Saraswati, 1984). Within this cultural understanding, an individual experiencing the unusual phenomena occurring during the

awakening of Kundalini would be supported and guided through the crisis toward a state of enhanced well-being of body and mind.

4.2.6 Summary

In yogic literature, Kundalini has been described as a potential force within the subtle energy body that resides at the base of the spine. When awakened, it is said to rise through each of the chakras, clearing blockages, which may in turn trigger a number of physiological, emotional, mental and spiritual changes. In the East, many years of rigorous training are undertaken in order to prepare for the awakening of Kundalini, and with the correct preparation Kundalini has been known to awaken smoothly, leading to increased health and higher functioning of the human being.

Although Kundalini and the associated subtle energy system has been a part of yogic philosophy for centuries, it is difficult to comprehend the concept of Kundalini from within a Western worldview. The very terminology that is used to describe the subtle energy system and the rising of Kundalini is laced with metaphor and the western language is limited in explaining such culture bound concepts. Here lies a danger that the concepts described in the Kundalini literature may be taken too literally. This can be seen in the 'new age' movement where there is a vast array of workshops and training focusing on the activation of Kundalini through various types of yoga, dance, crystals and meditation.

In the East, it is believed that the awakening of Kundalini in a body and mind with no context or framework in which to understand the healing processes taking place, may lead to serious psychological and physical

distress. Although it is also recognised that while there are a number of psychological and physiological changes taking place during the awakening of Kundalini that may require psychological adjustment, they are not in themselves indicative of mental illness.

As a growing number of individuals in Western societies are showing an interest in Eastern spirituality, it is imperative that mental health workers be familiar with the symptoms associated with the awakening of Kundalini. In a supportive environment, with people who have a good understanding of the Kundalini process, the course of treatment can be steered toward a positive healing experience that may be beneficial rather than detrimental to the person involved.

4.3: THE SHAMANIC CRISIS

4.3.1 The Shamanic Experience

The origin of the term 'Shaman' remains unclear as it arose from an oral tradition with no recorded documentation (Heinze, 1991). However the term has often been traced back to the Tungus reindeer herders of Siberia (Krippner, 1991, cited in Heinze, 1991).

Shamans were the first people known to develop a ritualised practice which explores and modifies consciousness in order to use altered states of consciousness for healing (Walsh, 2001). The Shamanic tradition imparts information and techniques that assist the apprentice in recreating the altered states, experiences, and abilities of their predecessors. Thus it is believed that

each successive generation can preserve and continually recreate the tradition and its accumulated wisdom and techniques.

It's the direct personal experience of the sacred that defines the mystic and permits Shamanism to be named the first mystical tradition of humankind (Walsh, 1989). In fact much of Shamanism focuses on techniques that enable the Shaman to enter these states (Walsh, 1989). Common techniques include ingesting mind-altering plants, chanting, intense concentration, dancing, drumming, jumping, fasting, running, visualising, engaging in or refraining from sexual activity, lucid dreaming and going without sleep (Krippner, 2000).

In order to work effectively within their culture the Shaman must master many skills, including: techniques to alter consciousness, diagnosing and treating illness, contacting the souls of the dead, interpreting dreams, prophesying and story-telling, practicing herbology, hexing tribal enemies, and predicting weather patterns (Heinze, 1991). A practitioner may master any combination of the above skills, but it is only those individuals who can access alternate states of consciousness at will, have the ability to successfully mediate between the sacred and profane, and are able to fulfil the needs of their community, that can be called a Shaman (Heinze, 1991). A thorough knowledge of non-ordinary realities and the ability to enter and navigate these landscapes enables the Shaman to serve as a bridge between the different worlds.

The Shaman also holds a priest-like role within their culture, although there is a major difference between the two. A priest holds a certain rank as socially initiated members of an organisation, whereas the Shaman has

gained certain powers of their own, as a consequence of a personal psychological crisis (Campbell, 1969).

During the Shamanic journey, the Shaman may experience their soul or spirit exploring other worlds or travelling to distant parts of this world. These travels take place in a threefold universe reflecting the upper, middle, and lower worlds, which make up the Shamanic view of the cosmos. The lower world contains within it several levels; it is often a place of tests and challenges, and it is here the Shaman acquires a 'power animal' that guides the Shaman toward a successful journey. The middle world is our familiar world, and through visions, Shamans journey over it unimpeded by barriers or distance, often returning with important information regarding hunting, weather, or warfare. The upper world may also contain several levels and the Shaman can move through them at will, often with the assistance of a helping spirit. It is here where teachers and guides may be found, and journeys in the upper world may be particularly ecstatic (Walsh, 1990a).

With practice, the Shaman becomes familiar with the landscape and inhabitants of the different worlds and is able to move throughout them as necessary and enlist the aid of appropriate helping spirits and guides in order to fulfil their role in the community. The Shaman is able to function efficiently in both the non-ordinary and ordinary realms of consciousness.

4.3.2 The Shamanic illness

Many Shamans begin their journey with a dramatic involuntary visionary episode that anthropologists call "Shamanic illness". During this time, the future Shaman might lose contact with the environment, appear to be

dying or going crazy, be plagued by mysterious, unaccountable pains or illnesses, develop bizarre eating disorders and experience hallucinations, visions and dramatic dreams (Grof & Grof, 1991). This can be an intense experience, which may last for weeks or years.

Although experiences of Shamanic crises vary in detail from culture to culture, they seem to exhibit the same basic themes. These include: descent to the realm of death, confrontations with demonic forces, dismemberment, trial by fire, communion with the world of spirits and creatures, assimilation of the elemental forces, ascension via the World Tree and/or Cosmic Bird, realisation of a solar identity, and return to the middle world, the world of human affairs (Halifax, 1979).

The concept of the “wounded healer” refers to the necessity of the initiate Shaman to enter into an extreme personal crisis in preparation for their new role as healer²¹ in the community. The illness becomes a medium to reach a higher place of consciousness, where the Shaman’s work takes place (Halifax, 1979). In order to become a Shaman the novice must understand how to integrate their experience and return to full functioning within their community. A profound and well-integrated Shamanic experience contributes to the development of ESP, creative inspiration, the ability to diagnose and heal diseases, and can be profoundly healing for the emotional and physical health of the future Shaman (Grof & Grof, 1989).

²¹ “Jung speaks of the wounded-healer as an archetypal experience, and he regards it as crucial amongst analysts in their treatment of disorders, particularly in the transference/counter-transference situation. The analyst’s inner psychological wound activates the same archetype in the patient, which in turn initiates healing. Thus, the patient too can bring healing to the analyst. (L. Storm, personal communication, November 20, 2007; see also, Jung, 1966; Wilmer, 1987)

4.3.3 Shamanism and Psychopathology

The experiences accompanying the Shamanic crisis and journey may be well mapped out and supported within a Shamanic culture but may seem incomprehensible to those from other cultures. In fact, early Western researchers diagnosed Shamanic experiences as schizophrenic, epileptic, neurotic, hysteric, idiotic as well as psychotic (Walsh, 2001).

The Shamanic experiences that have most often lead to the diagnoses, prognosis and treatment of schizophrenia, have been the altered state of consciousness induced by the Shaman, the rich imagery and visions that accompany it, as well as the belief that these visions are as real as their waking reality (Walsh, 1997). It was believed that these experiences might be due to a diminished sense of reality testing. In order to investigate the reality testing capacity of Shamans, Boyer, Klopfer, Brawer, and Kawai (1964, cited in Wright, 1994), administered the Rorschach inkblot test to groups of Apache Shamans, non-Shamans, and several Apache men who claimed to have Shamanic powers but were not recognised as Shamans. Their results indicated that the Shaman and non-Shaman groups both described the inkblots in a similar way, with each group demonstrating a high degree of reality testing. If individuals in the Shaman group suffered from schizophrenia, they would not have been able to describe the inkblots in a similar way to other members of their society.

Walsh (1990a) believes that the Shamanic journey differs from schizophrenia in a number of ways. The Shaman's experience is coherent, meaningful, and consistent with the purpose of the journey. The Shaman maintains good levels of concentration and control of the experience as well

as maintaining a clear sense of identity. In comparison, the person diagnosed with schizophrenia has difficulty finding meaning, is unable to concentrate or control their experience, and often loses their sense of identity. Whereas the Shaman's experience may be a source of wonder and delight, the person suffering from schizophrenia may find their experience terrifying. Shamans may display considerable intellectual and artistic abilities, great leadership skills and make significant contributions to their community, which would be a difficult task for the person diagnosed with schizophrenia. Noll's (1985) research supports these differences between schizophrenia and Shamanism. He compared the Shaman's reports of their experiences in altered states of consciousness to the symptoms of schizophrenia and other mental illness as listed in the DSM-IV(R). Results indicated that the Shaman's experiences did not match the criteria for mental illness as listed in the DSM.

A common view among mainstream anthropologists is that Shamans are psychologically disturbed individuals who have managed to adapt their psychopathology to social needs (Walsh, 1990b). This view has been supported by Silverman (1967), a psychiatrist, who claims that Shamanism is a form of socially sanctioned schizophrenia. He believes that both Shamans and people diagnosed with schizophrenia share abnormal perceptual experiences, profound emotional upheavals and non-reality-oriented ideation. He emphasises that the major difference between the two is the degree of cultural acceptance, understanding and resolution of the crisis. In primitive cultures the experiences are both cognitively and affectively beneficial to the individual and s/he is regarded as one with an expanded consciousness. However, when experienced within a culture which does not provide

understanding and support for this kind of crisis, the individual usually experiences an intensification of their suffering (Silverman, 1967).

Shamanic experiences have also been explained or dismissed as epilepsy on the basis of historical reports of seizures in some initiates. However, Walsh (1997) believes that these descriptions are typically too vague, clinically imprecise and based on recollections so long forgotten that they cannot be accurate enough to illustrate the incidence of epilepsy in Shamans.

Due to the dramatic changes in consciousness, identity, and behaviour that can accompany the Shamanic crisis, it has often been compared to hysteria, or possibly an unusual or culturally specific form of dissociation. Walsh (1997) suspects that dissociation²² and conversion²³ may account for some seizures or abnormal behaviours during the initiation crisis as well as play a role in the Shamanic journey and spirit possession. However, this does not mean that these phenomena should be regarded as nothing but dissociative disorders. Once again Walsh (1997) suspects that the historically imprecise information that these claims are based on, lack sufficient background to allow an accurate diagnosis. To date, the early western research presenting the Shaman as a psychotic, hysteric or schizophrenic individual, has not been supported by more recent research.

²² Dissociation involves a disruption in the usually integrated functions of consciousness, memory, identity, or perception (DSM-IV, 2000).

²³ Conversion is associated with the presence of symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition (DSM-IV, 2000).

4.3.4 The Shamanic crisis as Spiritual Emergency

Although a Shamanic crisis can resemble some types of psychopathology, within the appropriate cultural context these crises are understood as the calling for one to become a Shaman. If the initiate is supported, they will learn to successfully navigate the experience, cure their own illness and have the knowledge, intelligence and energy to become a healer within their community.

Holger Kalweit (2000) believes that the threefold sequence of illness, self-healing and development of healing powers is a universal, transpersonal pattern that we are only just beginning to understand. He believes that the Shamanic illness can be understood as a process of purification, giving access to the hidden and highest potentials of human existence. In contrast to the modern view that illness disrupts and endangers life, the Shaman experiences their illness as a call to restructure their life from within so they can hear, see and live with a higher state of awareness (Kalweit, 1988). Walsh (1990a) also views this process as a psychological and/or spiritual transformation. He explains that the experience of a symbolic death, or ego death²⁴ and rebirth is most likely to occur at times of overwhelming emotional arousal. When the arousal activates psychological tension and conflicts to extreme levels, it results in a crisis in which the former psychological balance cannot be maintained and the psyche's organisation temporarily collapses. In most situations the experience of being 'resurrected' after the Shamanic illness is accompanied by a feeling of euphoria. Grof and Grof (1989) believe

²⁴ Jung (1966) states: "dissolution of the ego in the unconscious, a state resembling death . . . results from the more or less complete identification of the ego with unconscious factors, or, as we would say, from contamination" (para. 501).

that the suffering annihilates or restructures former characteristics of the personality and one dies to an old way of being and is reborn anew.

It is believed that the Shamanic illness unleashes an underlying psychic knowledge that far exceeds the normal expressions of intellect and feeling (Kalweit, 2000). Shamans frequently show evidence of extraordinary energy and stamina, demonstrate control of altered states of consciousness, and have a good understanding of myths and rituals (Walsh, 1990a).

Ultimately, the Shaman becomes a leader within their society, with a strong mental constitution, a keen intellect and superior powers of concentration (Eliade, 1964). So, although the symptoms and behaviour of the person experiencing a Shamanic crisis can be seen as bizarre by both Western and tribal standards, Shamans not only recover, but may function remarkably well as leaders and healers of their people (Walsh, 1990a).

Grof and Grof (1991) have suggested that the Shamanic journey is a universal experience, and that many people in non-Shamanic cultures have experienced conditions similar to the Shamanic illness. They believe that these experiences can be triggered by experimentation with psychedelic drugs, holotropic breathwork²⁵, Shamanic workshops, extreme states of physical or emotional distress, as well as various other events. In a society that lacks an understanding of the Shamanic illness, the experience is most often reduced to and treated as a psychotic disorder. With no appropriate support, the experiencer is unable to find meaning, or gain an understanding, of the significance of their experience and finds it difficult to return from the experience positively transformed.

²⁵ Grof and Grof developed Holotropic Breathwork, a substance-free method believed to allow access to nonordinary states of consciousness for the purpose of self-exploration and healing. See Grof (1988).

4.3.5 Summary

Shamanism is an ancient tradition occurring throughout many cultures around the world. The initiation of the Shaman often involves a journey through an altered state of consciousness, including an encounter with symbolic death and rebirth. Within the appropriate cultural context, this journey is supported and the Shaman returns from the journey healed and transformed. The Shaman is then ready to heal the individual and the society, using the knowledge and help received during their journeys.

It is difficult to grasp the complexities of the expansive Shamanic worldview from the mechanistic and materialistic worldview of the West. However, in order to gain a thorough understanding of the Shamanic tradition (including the rituals, ceremonies and procedures used to induce non-ordinary states of consciousness) we must look beyond our limited belief structures. We must also refrain from imposing our Western cultural ideas and diagnostic categories that reduces the Shamanic experience to psychopathology, as this has not been supported by modern research. It is also of equal importance not to attribute symptoms of mental illness to a Shamanic crisis when one has such a limited understanding of Shamanic processes.

While the Shaman and the person experiencing psychosis may both have access to non-ordinary states of consciousness, the Shaman is able to 'navigate' the landscape and benefit from the experience, while the psychotic person cannot make sense of their experience, thus leading to further distress and illness. However, just as the Shaman learns to understand and navigate the inner landscape of their process, so too, with greater understanding,

support and guidance, the 'psychotic' may be able to gain some insight, and return from their ordeal positively transformed.

4.4: PEAK EXPERIENCES

4.4.1 The Peak Experience

Peak experiences have been reported by millions of people both males and female of all ages, from diverse social and educational backgrounds with various religious affiliations (Austin, 1998). During his initial research, Maslow (1971) believed that all individuals were capable of peak experiences and even came to the expectation that all participants in his research would report a peak experience. Those who did not, he called non-peakers, not because they couldn't have this type of experience but because he believed that they somehow suppressed or denied them. Maslow considered "non-peakers" to be rational or mechanistic and therefore regarded their peak experiences as a form of insanity. He believed that the individual who is afraid of losing control would desperately try to stabilise or hold onto their reality and push the peak experience away. Maslow also believed that individuals who were emotionally healthy, self fulfilled and self-actualised²⁶ were more likely to encounter a greater number of peak experiences than individuals who did not possess these attributes.

Maslow's (1971) research demonstrated that peak experiences can occur in the middle of everyday events in the most common of surroundings. Maslow was surprised to find many of his undergraduate students having

²⁶ A term used to describe the process of coming to know oneself and one's life.

peak experiences which they described in similar language to that used by spiritual leaders in the East and West, thus implying that one does not need to be a religious mystic to experience a peak state (Hoffman, 1988). In fact Maslow said:

The great lesson from the true mystics, from the Zen monks, and now also from the humanistic and transpersonal psychologists - that the sacred is *in* the ordinary, that it is to be found in one's daily life, in one's neighbours, friends, and family, in one's backyard. (Maslow, 1971, p. x)

Maslow (1999) presented a summary of the characteristics of the peak experience:

- 1) The experience of the object tends to be seen as a whole, as a complete unit, detached from relations, possible usefulness and purpose.
- (2) There is total attention, fascination or complete absorption in the object or experience.
- (3) There is an ability to perceive the world as independent from the self and others and see the nature of the object in itself.
- (4) Perception is richer.
- (5) Perception can be relatively ego-transcending, self-forgetful and egoless. The perceptual experience can be organised around the object as a centring point rather than being based around the ego.

- (6) The peak experience is felt as a self-validating, self-justifying moment which carries its own intrinsic value with it. It is seen as an end-experience rather than a means-experience.
- (7) There is a disorientation of time and space; the person is subjectively outside of time and space.
- (8) The peak experience is good and desirable; it is intrinsically valid, perfect and complete.
- (9) Peak experiences are more absolute and less relative, they are timeless and spaceless and detached from ground.
- (10) Perception may be undemanding, contemplative, humble and passive.
- (11) The emotional reaction in the peak experience has a special flavour of wonder, awe, reverence, humility and surrender before the experience as something great.
- (12) The whole world is seen as a single rich live entity or one part of the world is momentarily perceived as the entire world.
- (13) There is an ability to abstract without giving up concreteness and the ability to be concrete without giving up abstractness.
- (14) Many dichotomies, polarities and conflicts are fused, transcended or resolved.
- (15) There is a complete loving, uncondemning, compassionate and acceptance of the world and the person.
- (16) Perception tends to be idiographic and non-classificatory, things are seen as unique.

(17) There is a momentary complete loss of fear, anxiety, inhibition, defence and control, a giving up of renunciation, delay and restraint.

(18) The person tends to become more integrated, individual, spontaneous, expressive, courageous and powerful.

(19) There is a true integration of the person on all levels.

The peak experience is not just limited to adults. Hoffman (1998) cites an exploratory study by Maslow's biographer revealing that young children under the age of 14 are capable of peak experiences. Hoffman went on to establish a typology of nine categories of peak experiences in children including (1) uplifting experiences in places of scenic grandeur, (2) inspiring encounters with nature in one's own backyard, (3) near-death or crisis episodes, (4) peak moments during intense and personalised prayer, (5) spontaneous moments of bliss or ecstasy, (6) profound insights about self-identity, life and death, and related topics, (7) exalted experiences in formal religious settings, (8) uncanny perceptions with lasting impact and (9) unforgettable dreams.

Peak experiences are most likely to occur at times where we are most attentive or deeply absorbed in the world around us. According to Maslow (1971) the peak state tends to be triggered by any experience of perfection or excellence. He found the most common triggers to be music and sex, although negative or tragic events have also been found to trigger the peak experience.

Laski (1962) revealed that art, being in nature, experiences of love, involvement in religion, exercise and movement, creative activities,

appreciating beauty, childbirth, knowledge of science as well as recollection, introspection and poetic knowledge are all triggers for the experience of ecstasy. This same research revealed that natural settings triggered approximately 20-45% of these experiences. The most common natural settings included star-lit nights, sunrise and sunsets, mountains or hills, spring and autumn days, trees, flowers and the sweet smell of the countryside, flight and songs of birds, water, light and wind. Various art forms such as sculpture, painting and music as well as being in the presence of the pyramids in Egypt, Hindu temples, Gothic cathedrals, Moslem mosques or the Taj Mahal can also trigger a peak or powerful experience of unitive consciousness (Grof & Grof, 1991).

While Maslow (1999) differentiates between two types of peak experience, the relative and the absolute, he claims that the experience can include both. During the relative experience the individual remains aware of subject and object, the experience is an extension of self and this is not seen as true mystical experience. In contrast, absolute peak experiences are timeless and spaceless, they are characterised by unity or non-duality, where the subject and object become one and are comparable to experiences of the great mystics. Although relatively rare, Maslow (1970) found powerful peak experiences to include the feeling of a limitless horizon opening into vision, the feeling of being simultaneously extremely powerful and powerless, feelings of great ecstasy, wonder and awe along with displacement of time and space. According to Maslow (1986), these experiences lie at the core of moments of ecstasy and deep mystical and transcendental experiences such as those explored by William James.

Maslow (1999) is well known for his hierarchy of needs in which self-actualisation sits at the highest level. Maslow defined self-actualisation as

An episode or a spurt in which the powers of the person come together in a particularly efficient and intensely enjoyable way, and in which he is more integrated and less split, more open for experience, more fully idiosyncratic, more perfectly expressive or spontaneous, or fully functioning, more creative, more humorous, more ego transcending, more independent of his lower needs, etc. He becomes in these episodes more truly himself, more perfectly actualising his potentialities, closer to the core of his Being, more fully human. (p.106)

Maslow (1971) listed eight behaviours that steer the individual toward self-actualisation. These include (1) experiencing things with full concentration and total absorption, (2) seeing life as a process of making choices toward growth, (3) self-awareness, (4) honesty and taking responsibility for one's actions, (5) to be courageous in trusting our own judgment, (6) develop one's own potentials, (7) set conditions to allow peak experiences, and (8) have the insight to identify and courage to give up ego defences.

In order to learn more about the characteristics of self-actualised people, Maslow (1970) carefully selected his interviewees for their absence of neurosis, psychopathic personality or psychosis and their ability to fully utilise their talents, capacities and potential. He selected these people from his circle of friends and acquaintances as well as using detailed records of prominent public figures who fitted the above description. However Maslow's selection

criteria was criticised by May (1993) as it eliminates many people including some great mystics, who experienced a period of depression or anxiety on their spiritual path. He gives an example of St. John of the Cross, who suffered from depression during his dark night of the soul before reaching a state of union with the Divine.

Nonetheless, Maslow's research (1970) indicated that the major characteristics of self-actualised people included; having a clear perception of reality, the acceptance of self and others, spontaneity and simplicity, problem centred and solution focused, they were autonomous and enjoyed solitude, continued freshness of appreciation, enjoyed more mystic and peak experiences, share a sense of kinship with others, they enjoyed deeper interpersonal relations, democratic values with a sense of humility and respect, they are reality centred, able to discrimination between means and ends, honest and genuine, able to discriminate between good and evil, un-hostile sense of humour, capacity to be creative, they resisted enculturation and were not susceptible to social pressures to conform.

Maslow (1970) indicated that the intensity of the peak experience can shift into a more voluntary, continued state of inner serenity or cognitive blissfulness. He termed this the 'plateau' experience and expressed that it often required a lifetime of long hard effort to reach this state.

4.4.2 Other Models of the Peak Experience

Maslow's description of the peak experience is similar to the description given by Rogers (1980) for the "fully-functioning person". Rogers originally described this person as being open to experience, process

orientated, caring, non-materialistic, anti-institutional, holding an inner sense of power, somewhat sceptical of science and technology, having a desire for authenticity, wholeness, intimacy and the spiritual. Like Maslow, Rogers was aware that only a minority of the population reached this state and of these, only a few possessed each of the characteristics.

Maslow also considered the height of the peak experience similar to cosmic consciousness (Bucke, 1923/1969) and the mystical experience as outlined by James (1902/2007), who identified four characteristics of the mystical experience: (1) Ineffability; the experience defies expression, its quality must be experienced, it cannot be transferred, it is more like a state of feeling rather than intellect. (2) Noetic quality; a state of knowledge providing insights into the depth of truth beyond the grasp of the intellect, illuminations and revelations of significance transcending time and space. (3) Transiency; mystical states cannot be sustained, they are fleeting, rarely lasting up to half an hour or two hours at most, once faded they can be somewhat imperfectly reproduced. (4) Passivity; the individual's will is suspended and one is held by a superior power, various phenomena such as automatic writing, trance or prophetic speech are experienced and although not often recalled the individual senses their importance.

May (1993), however, believes that the peak experiences collected by Maslow are relatively superficial in comparison to, and bear little resemblance to, the mystical experiences or the cosmic consciousness outlined by James and Bucke, which implied a supernatural or divine origin. It has been noted elsewhere that caution must be taken not to superimpose psychological models of growth onto models of spiritual growth due to a number of

significant differences in the way self-awareness, spirit and self-transcendence are defined and used within the fields of psychology and theology (DeHoff, 1998).

The peak experience has also been associated with peak performance as described by Privette (1983) as a superior level of human functioning. During peak performance, the individual is spontaneous, efficient, creative, joyous and totally absorbed and focused on the task at hand with no awareness of time and space. Peak performance shares a number of these similarities with peak experiences, but they differ as peak performance focuses on the self as well as the object of value, whereas the peak experience is often transpersonal in nature.

Peak performance also shares some characteristics with the concept of 'Flow', which is experienced as "a unified flowing from one moment to the next, in which we are in control of our actions, and in which there is little distinction between self and environment, between stimulus and response, or between past, present, and future" (Csikszentmihalyi, 1975; p.36). A number of characteristics are present during the experience of flow: There is balance between the challenging nature of the task and the skills required to complete the task; there is a merging between one's actions and awareness; the individual has set a self-determined goal and receives immediate and clear feedback for their efforts; the individual gives the task their full concentration; there is a feeling of being in control without trying to control the situation; there is a loss of self consciousness, an altered sense of time and the task is intrinsically rewarding (Csikszentmihalyi, 1990).

A comparative analysis undertaken by Privette (1983) outlined a number of qualities shared by the peak experience, peak performance and flow. First, all three phenomena are positive subjective experiences containing absorption, attention and a clear focus. These elements are seen as critical for the thorough participation required for the superior functioning of peak performance. These elements may also be equally important for the enjoyment and joy present during flow and the peak experience. A further characteristic associated with all three phenomena is the spontaneous, effortless, integrated process of letting things be as well as the experience of integration and personal identity gained through a sense of responsibility and power.

An awareness of power is also present in all phenomena but is most strongly associated with peak performance, whereas joy and valuing are also present in all phenomena but considered synonymous with peak experience. Peak experience and peak performance are also characterised by a sense of newness of perception and process, they can occur spontaneously or be triggered by something in the environment and often contain a strong impulse toward closure or completion. In contrast, experiences of flow are sought and planned by participating in intrinsically rewarding activities, allowing or facilitating flow through goal planning and using one's skills to complete the activity (Privette, 1983).

4.4.3 The Peak Experience and Psychopathology

Although it's possible that individuals experiencing mental illness may have a peak experience, these experiences are not in themselves indicative

of mental illness. It is also possible that a powerful peak experience may be misdiagnosed as some form of mental illness by health professionals who do not have a thorough understanding of such extreme states.

Alternately, many individuals having a powerful peak episode may also misinterpret their experience as a sign of madness. For example: During an absolute peak episode individuals may have an experience in which they believe to be in contact with their divine nature. If this experience remains attached to their ego it may take the form of a psychotic delusion of grandeur. However, if the individual is able to understand that they are connecting with a genuine mystical insight, they may be able to embrace the experience and enjoy the positive benefits (Grof, 1993).

There are a number of characteristics associated with the peak experience that may mimic psychopathology including temporary disorientation in time and space, changes in perception, heightened sensitivity and a reluctance to communicate. These qualities are usually transient and do not persist past the natural conclusion of the peak experience. However, a reluctance to communicate with others about the experience may persist as many people find themselves afraid to speak about their experience in fear of being labelled crazy (Noble, 1987), while some are unable to find the right words to adequately explain their experience.

A number of characteristics indicative of positive mental health occur more frequently in peak experiencers as compared to non non-peakers. These include abstract thinking, open-mindedness and flexibility, higher intelligence, self-sufficiency, greater assertiveness, imagination and sensitivity, free thought, autonomous, self trusting, independent and spontaneous

(McClain & Andrews, 1969). Some positive therapeutic effects of the peak experience include the removal of neurotic symptoms, a sense of being graced or blessed, the release of creativity and spontaneity, positive changes in worldview and interactions with others, and a growing tendency to view oneself and one's life in a positive and healthy manner (Maslow, 1971).

Given the number of positive attributes of the peak experience, it would seem unlikely that they are indicative of mental illness. In fact it could be suggested that an individual who does not encounter a peak experience may not be a fully functioning integrated human being.

4.4.4 The Peak Experience as Spiritual Emergency

As the peak experience is positive, transient and self-limiting, there should be no reason why it would lead to adverse consequences for the individual. However, Grof believes that it is due to the lack of real understanding of non-ordinary states of consciousness in the Western culture (1991), as well as misconceptions concerning spiritual matters within psychiatry (2000), that many people experiencing peak states are viewed through the lens of psychopathology. Unfortunately these factors result in an inability to recognise, value, accept and support the individual through their peak experience which can in turn result in further alienation.

Noble (1987) indicated that many peak experiencers undergo a period of doubting their sanity, which may be exacerbated by their reluctance to communicate. Following the experience is a painful period of readjustment, which is characterised by withdrawal, isolation, confusion, insecurity and self-doubt. During this time individuals may experience mild and temporary

psychological disturbances such as panic, anxiety and restlessness and possibly more severe reactions such as depression.

If the peak experience is supported and allowed to run its natural course, it can lead to a profound and lasting transformation in emotional and physical health, life values and an increased appreciation for life. The experience can also facilitate a more loving, accepting and honest way of communication with others as well as reducing levels of intolerance, aggression and unrealistic ambitions (Grof & Grof, 1989; 1991). In fact, according to Maslow (1999) these experiences should be considered “supernormal” rather than pathological as they play a role in the movement toward “self-realisation”.

4.4.5 Summary

Maslow emphasised the positive side of human behaviour and coined the term “peak experience” to describe a superior mode of human functioning characterised by intense happiness, fulfilment and enhanced psychological performance.

The peak experience shares a number of similar qualities with peak performance and flow, demonstrating various optimal levels of human functioning, with the relatively rare intense peak experience sharing characteristics with mystical experiences. Although it is ultimately a positive, enriching experience leading to self actualisation, in the past the peak experience has been loosely associated with various forms of psychopathology. Looking through the lens of psychiatry, some of the characteristics of the peak experiences may be seen as pathological, but the

majority of research has highlighted the superior psychological functioning of the peak experimenter.

If the individual has no conceptual framework, which allows them to understand their peak experience, and they are surrounded by others who also have no insight into the phenomenon, the individual may doubt their sanity and be thrown into a state of spiritual emergency. It is important that the changes taking place within the individual during the peak experience be recognised and supported so the individual can be guided toward a positive outcome conducive to increased psychological functioning or “self-actualisation”.

4.5: THE CRISIS OF PSYCHIC OPENING

*“Without Going outside,
You may know the whole world
Without looking out the window
You may see the ways of heaven.”*

*Tao De Ching
Lao Tsu, six century BC.*

4.5.1 Psychic Opening

Throughout history a number of spiritual traditions have described practices which if followed improve one’s mental and physical health. Some traditions contain practices, which help to quieten the mind, which in turn seem to increase the possibility of psychic images or perceptions to emerge in one’s consciousness. During this period of increased psychic awareness or psychic opening, a number of unusual phenomena can be experienced such

as out-of-body experiences (OBEs), strong intuitions, or episodes of *telepathy*.

Reports of this type of psychic phenomena have been recorded throughout history in the mythology, fairy tales, spiritual and religious texts, and more recently, personal anecdotal reports have become commonplace. For example, the familiar words of “I was just about to call you” or “I was just thinking about you” are often heard when calling someone on the telephone. Although these are interesting phenomena, anecdotal stories do not provide objective evidence of psychic abilities.²⁷

Much of the research into psychic phenomena has been concerned with proving its existence (Thalbourne & Storm, 2005) or measuring people’s belief in psychic experience (Irwin, 1993). This thesis is not concerned about whether or not psychic experience is objectively true or can be proven. It simply attempts to provide a brief introduction into the various types of psychic phenomena often reported to arise during a spiritual emergency.

Anecdotal reports have suggested that abilities can spontaneously awaken in a person. For some it may be non-recurrent, such as is the case of after-death communication, where one can sense the presence of a recently departed loved one (Wright, 2006). Others may continue to experience psychic phenomena throughout their lifetime as in the case of the well know practicing psychics Edgar Cayce (1877-1945) and Uri Geller.

A recent on-line Gallup survey indicated that 41% of Americans believe in ESP, 31% believe in telepathy, 26% believe in clairvoyance, 21% believe in

²⁷ For meta-analytic support for the psi hypothesis, see Storm (2006b; 2006c).

communication with the deceased and 9% believe in channelling.²⁸ However, it is more difficult to ascertain how many people actually experience psychic phenomena. This may be partly due to the fact that psychic experiences generally fall outside what is considered to be 'normal' and people may be fearful or embarrassed to report such an incident. It may also be due to the difficulty in measuring the occurrence of psychic phenomena in a non-experimental environment. To sidestep this difficulty surveys can be taken to measure incidents of past psychic activities. Such a survey of college students indicated that 41% claimed to experience psychic phenomena, with 46% of these students claiming that their experiences were valuable. The authors found that these results were similar to those found in previous research with college students (Kennedy, Kanthamandi and Palmer, 1994).

A number of predictors for sensitivity toward psychic experience have also been found (Wright, 2006). First, psychic abilities appear to occur more often in people from families with a history of psychic experience and/or where they are accepted as a part of life. This theory receives support from the Shamanic cultures where the role of the Shaman is seen as hereditary, often passed on from father to son (Eliade, 1964). Second, people who are a part of a multiple birth tend to report higher levels of psychic ability. Third, people suffering serious childhood trauma, such as living with alcoholic, angry or abusive parents, within their first 10-12 years of life tend to report more psychic phenomena. Further support of this last theory may be found in Ring's (1992) research which identified that people who were exposed to or threatened by violence, sexual abuse or other trauma as children may have

²⁸ See www.gallup.com/poll/16915/Three-Four-Americans-Believe-Paranormal.aspx (retrieved November 25, 2007)

learnt to dissociate and in doing so were more likely to 'tune into' other realities.

Wright's (2006) investigation also revealed that in general, women experience more psychic phenomena than men and the 'typical' person least likely to have psychic experiences is male, not part of a multiple birth, enjoyed a happy childhood, and comes from a family who expressed no interest in paranormal activity.

4.5.2 Types of Psychic Opening

Within the field of parapsychology²⁹, psi (Ψ), the 23rd letter of the Greek alphabet, is used as a neutral term to represent paranormal³⁰ processes. Although two categories are generally recognised, *extrasensory perception* (ESP; also referred to as paranormal cognition), and *psychokinesis* (PK; also referred to as paranormal action), it is suggested that ESP and PK may be different aspects of the same process.³¹

The word psychic is derived from the Greek word *psychikos*, which refers to mental phenomena or the human mind.³² The term is commonly used to explain the ability to perceive certain phenomena, which usually lie hidden from the five physical senses, through means of extra sensory perception (ESP).

²⁹ Parapsychology is "the scientific study of paranormal or ostensibly paranormal phenomena, that is psi" (Thalbourne, 2003, p. 84).

³⁰ A phenomenon is "paranormal if it refers to hypothesized processes that in principle are physically impossible and outside the realm of human or animal capabilities as presently conceived by conventional scientists" (Thalbourne, 2003, p. 83)

³¹ See Storm and Thalbourne (2000) and Thalbourne (2003).

³² As a noun, psychic refers to an individual who possesses psi [paranormal] ability of some kind and to a relatively high degree" (Thalbourne, 2003, p. 96)

Traditionally ESP tends to fall into four categories: (1) *Telepathy*, mind to mind communication, (2) *Clairvoyance*, the acquisition of knowledge without using the five senses, (3) *Precognition*, knowledge of a future event through non-ordinary means and (4) *Psychokinesis*, direct influence of the mind on a physical object or an event. However, Shoup (2002) believes that these categories and descriptions are well out of date, misleading, and pose an impediment to greater understanding of the phenomena. He suggests that advances in scientific research have indicated that these categories are not clearly distinguishable and are manifestations of a deeper reality, yet to be fully appreciated.

Although some types of psychic phenomena have been documented for centuries, rigorous scientific investigation, involving the measurement of various facets of these phenomena, have returned mixed results. With many of the phenomena lying beyond the measuring capacity of modern science, it is difficult to reach a reliable, valid, and informed conclusion. Despite this restriction, a number of prominent psychologists and psychiatrists from outside the field of parapsychology have explored psychic experiences from within the psychological framework including James, Jung, Assagioli, Grof and Perry.

The following section will not attempt to provide a comprehensive review of the literature, but will provide the reader with sufficient knowledge to understand how the opening of a variety of 'psychic' experiences may be associated with a spiritual emergency.

Channelling (a form of ESP) is a phenomenon in which "a person purports to transmit information or messages directly from a personality or

consciousness other than his or her own, usually through *automatic writing* or trance speaking; this other personality usually claims to be a non-physical spirit or being” (Hastings, 1990, p. 99). During the transmission of information, it is believed that the receiver loses their identity and can take on the other personality’s body image, posture, gestures, facial expression, emotions and thought processes (Grof, 2000). It is well known in the anthropological literature that one of the skills mastered by the Shaman is entering into non-ordinary states of consciousness in order to receive insights for diagnosing and treating illness (Heinze, 1991).

The term *psychokinesis* is derived from the Greek words *psyche* meaning ‘breath,’ ‘life,’ or ‘soul,’ and *kinein* meaning ‘to move’. *Psychokinesis* then refers to the “direct influence of mind on a physical system that cannot be entirely accounted for by the mediation of any known physical energy” (Thalbourne, 2003b, p. 98). Occurrences of *psychokinesis* have been recorded since ancient times including incidences of levitation, miraculous healings, luminosities, and more recently the moving of objects or bending of spoons. Apparently these phenomena can occur spontaneously and deliberately, indicating that psychokinesis may be both an unconscious and conscious process (Heath, 2003).

The word ‘*precognition*’ is derived from the Latin *præ* ‘prior to’ and *cognito*, ‘a getting to know’. It is a form of ESP in which the individual is able to gain information about some future event that cannot be deduced from normally know information in the present (Thalbourne, 2003b, p. 90).

This is not to be confused with *clairvoyance*, derived from the French, *clair* ‘clear’ + *voyant* ‘seeing’, thus meaning ‘having insight’ or ‘seeing clearly’,

originally from the Latin *videre* 'to see' (Thalbourne, 2003, p.18). *Clairvoyance* involves the acquisition of information concerning an object or contemporary physical event, assumed to derive directly from an external physical source and not from the mind of another person. Typically, *clairvoyance* involves visual impressions but it may also include auditory impressions, known as '*clairaudience*' or kinaesthetic impressions (Thalbourne, 2003b).

In contrast to this, *telepathy*, from the Greek *tele* 'distant' and *pathe* 'occurrence' or 'feeling', refers to the ability to acquire information concerning the thoughts, feelings, ideas, sensations, images or activity of another conscious being through what is believed to be mind to mind transference of information (Thalbourne, 2003b, p. 125). *Telepathy* has long been recognised as a traditional means of communication in early Australia among the Nyul-nyul, Gringai, Minying, Bundulung and Gidabul people (Rose, 1956), as well as in certain native groups in America who also recognise telepathy as part of the *mituneyihchikan* or 'whole mind' (Junker, 2003).

According to the DSM-IV-TR (2000) a hallucination is false sensory perception occurring without external stimulation of the relevant sensory organ. There are a number of different types of hallucinations including the following: (1) Auditory hallucinations involve the perception of sound, most commonly of voices, whose source is perceived as being external; (2) Gustatory hallucinations involve the perception of taste, which usually tends to be unpleasant; (3) Olfactory hallucinations involve the perception of odour, such as the smell of burning incense; (4) Somatic hallucinations involve the perception of a physical experience localized within the body, such as a feeling of electricity; (5) Tactile hallucinations involve the perception of touch,

most commonly the sensation of electric shocks or the sensation of something creeping or crawling on or under the skin; (6) Visual hallucinations involve the sense of sight, including the perception of seeing formed images, such as of people, or of unformed images, such as flashes of light. In the midst of a hallucination, individuals may or may not have insight into the fact that they are having a hallucination.

Hallucinations are usually considered abnormal by psychiatrists with the exception of them occurring within a dream, prior to sleep (i.e., the *hypnagogic* state) or awakening from sleep (i.e., the *hypnopompic* state). However, the DSM also acknowledged that transient hallucinatory experiences may occur in people without a mental disorder (DSM-IV-TR, 2000).

The Out-of-Body-Experience (OBE) has been described as “an altered state of consciousness in which the subject feels that his mind or self-awareness is separated from his physical body and this self-awareness has a vivid and real sense about it, quite different from a dream” (Monroe, 1985, p. 276). During the OBE there is no clouding of consciousness and the experiencer is absolutely certain that they are not dreaming. Research has indicated that the OBE is not associated with stress or illness, as the majority of OBEs seem to occur when the experiencer is relaxed and least expecting them (Monroe, 1985). In Shamanic cultures it is well known that the Shaman has the ability to enter into an altered state of consciousness and travel widely without the aid of their physical body (Walsh, 1990a; see also Chapter 4.3). OBEs have been widely reported to occur during the near death experience,

where empirical research has validated their existence (Ring, 1982, 1985; see also Chapter 4.7).

Another type of phenomenon that can occur in increasing frequency during an episode of psychic opening is 'synchronicity'. Jung first used the word synchronicity to explain the 'acausal connecting principle' that accounts for 'meaningful coincidences' in physical and psychological phenomena (Jung, 1960b). Jung believed that many psychic and physical events thought to be coincidences were not due to chance though they appeared chance-like, but were somehow related to one another on a deeper level (Jung, 1960b). The exploration of meaningful coincidences led Jung to believe that the archetypes³³ of the collective unconscious were not limited to the 'intrapyschic' domain, but possessed a 'psychoid' nature, thus belonging to neither the realm of the psyche, nor that of material reality.

Experiences in this realm of the collective unconscious frequently involve physical events in the external world and although they are often considered impossible by our current scientific worldview, they are sometimes observed by many, thus they can become consensus reality (Grof, 1993; see also Jung, 1960b). Grof (1993) described three types of 'psychoid' experiences: (1) inner experiences that are synchronistic with events in the material world, (2) events in the external world that are associated with inner experiences that traditional science would deem impossible, and (3) experiences where mental activity manipulates consensus reality (e.g., psychokinesis and ceremonial magic).

³³ See Chapter 4.9, The Central Archetype.

4.5.3 Psychic Opening and Psychopathology

Within the current psychiatric framework using the DSM as a diagnostic tool, individuals claiming to perceive meaningful coincidences may be diagnosed with anything from 'projecting special meaning into purely accidental events', through to suffering from 'delusions of reference' (Grof, 2000, 2001). Grof believes that this diagnosis may be made in situations where people are experiencing valid synchronicities as part of their spiritual emergency.

Cross cultural psychiatric research has reported that experiences, which occur infrequently in one culture may be perceived as psychopathology, but in a culture where this is a common occurrence, this same experience may be regarded positively. Neppe and Smith (1982) believe that if a person lives in a culture that does not accept their claimed 'psychic' ability, they are likely to act out in one of the following ways: (1) The individual may deny or suppress their experiences, which may in turn express itself in a variety of compensatory behaviours; (2) The individual may face social rejection, which may interfere with functioning within the community and lead to distress or anxiety; (3) The individual may become overwhelmed with their experiences, they become uncertain if their experiences are real or imagined which may lead to disturbances in reality testing; (4) The 'psychic' experiences could potentially precipitate psychosis or alternatively (5) the individual may reject the mainstream cultural belief, accept their experiences, and join a subculture which accepts the experiences.

The acceptance of various 'psychic' abilities is common in certain 'preliterate' cultures, particularly in those where 'diviners' and 'indigenous healers' are highly regarded for their ability to gain information or influence

events from means other than those conventionally accepted. One such ability, 'magical thinking' (e.g., telepathy and clairvoyance), although accepted as normal phenomena within the culture could be perceived as schizophrenic thought disorder using the DSM-IV-TR criteria. While 'magical thinking' can be a symptom of schizophrenia, it should be noted that even within a culture where this ability is accepted, the people of this culture are still able to recognise when one is exhibiting valid psychic ability and when they have departed from 'normal' behaviour (Neppe & Smith, 1982). Unfortunately, even though measures have been taken to make the DSM-IV-TR more culturally and spiritually aware³⁴, many psychiatrists would still make a diagnosis of psychopathology without a full investigation into the background and cultural beliefs of the patient.

Within the western culture, it has been suggested that people who believe in psychic abilities may possess certain psychological characteristics, which make them more likely to misattribute the cause of 'psychic' phenomena to normal experiences. However, a research review by Wiseman and Watt (2006) examined the relationship between belief in 'psychic' ability and a number of psychological measures and found inconsistent results. Other research has investigated the connection between dissociation and various 'psychic' phenomena including telepathy, clairvoyance, and OBEs, which have been reported in conjunction with dissociative experiences. Richards (1991) used the Dissociative Experiences Scale (DES) with a non-clinical adult population experiencing a high level of psychic activity and found the results confirmed previous findings, indicating that although these

³⁴ 'Religious or Spiritual Problem' was accepted as a new diagnostic category (Code V62.89) in the Diagnostic and Statistical Manual-Fourth Edition (APA, 1994).

experiences may be correlated with dissociation, they are not indicative of pathology. Further, 81.5% of the participants believed that their 'psychic' experiences had a positive or inspirational effect on their lives suggesting they may be part of a healthy developmental process.

4.5.4 Psychic Opening as Spiritual Emergency

During a spiritual emergency it is common to experience the emergence of, or an increase in 'psychic' abilities. The emergence or increase of these phenomena can become disturbing as they may be difficult to dismiss, and they seriously challenge one's understanding of reality. For example, in the awakening of so-called 'mediumistic' abilities, one has the sense of losing one's identity and taking on that of another. An accomplished Shaman or spiritual healer may be able to use such an ability at will, in a controlled manner with the understanding of how to make a safe return to their own identity. However, during a crisis of psychic opening with the rapid and unexpected change in identity along with no understanding of the 'mediumistic territory', one may become frightened and disturbed. A further difficulty can present itself when an individual experiences accurate *precognition* of future situations, *clairvoyant* perception or *telepathic* abilities and indiscriminately verbalises accurate insights to others. As well as frightening the person with the new ability, this can frighten and irritate others to such an extent that it may become a contributing factor for psychiatric intervention (Grof, 2000).

When the individual becomes familiar with the emergence of 'psychic' abilities, they may become fascinated with the phenomena and interpret the

emergence as an indication of their spiritual superiority (Grof, 2000), which could be diagnosed by traditional psychiatry as delusion of grandeur. With one of the goals of the spiritual path being to transcend the ego, attachment and fascination with these phenomena is regarded as an obstacle to the pursuit of genuine spiritual growth (Caplan, 1999). Most of the 'psychic' abilities emerging during the spiritual emergency tend to be temporary, but for some individuals the successful resolution of the crisis is associated with the emergence of a new capacity or talent such as an increase in creativity, intuitive ability or, in rare circumstances, the development of a genuine 'psychic' gift (Grof & Grof, 1989, 1991).

4.5.5 Summary

During the crisis of so-called psychic opening, a number of ostensibly psychic phenomena are experienced. In some spiritual or mystical traditions the emergence of these phenomena are well known and can be utilised, or can pose a danger in sidetracking the practitioner from their practice. In some cultures, psychic abilities are used for healing or communication and in modern culture 'gifted' people such as 'medical intuitives' effectively use their 'psychic' abilities to heal and assist healing.

Certain predictors toward 'psychic' sensitivity have been found and although many people report experiencing 'psychic' phenomena, scientific research has received mixed results. Although there have been reports that the experience of 'psychic' phenomena has had a positive and beneficial role in peoples lives, the influx of phenomena may become too great, too frightening and confusing and thus may lead to psychopathology. However,

many individuals who have allowed their crisis of 'psychic' opening to come to a natural completion have gained new insights and increases in creativity and intuition.

Placing 'psychic' experiences at the fringe, outside the discipline of psychology into the area of parapsychology, which is generally regarded as a controversial research field by academia, makes it difficult to reach adequate conclusions about these experiences. It is believed that one of the most fruitful sources for psychology, if it is to make further progress, will be the investigation of phenomena that do not fit into the current scientific paradigm (Iping-Peterson & Roll, 1994).

4.6: THE PAST-LIFE EXPERIENCE

4.6.1 The Past-life Experience

Reports of Past-Life Experiences (PLEs) are most commonly found in South East Asian countries holding a cultural belief in reincarnation, including northern India, Sri Lanka, Burma and Thailand. A number of recorded cases have also been found in south central Turkey, Lebanon, Syria, West Africa and the north-western region of North America, with a growing number of reports in Europe and South America. There have also been a smaller number of cases reported among people who don't hold a belief in reincarnation (Stevenson, 1987).

Grof and Grof (1989, 1991) believe that experiences similar to these inspired the Indian concepts of rebirth and the law of karma, which maintain

that our existence consists of a chain of successive incarnations with our present life shaped by debits and merits of the preceding ones, and forge our destiny of the future.

Spontaneous childhood recollections of PLEs are often triggered by memory cues such as travelling through an area where the child claims to have lived or seeing someone whom the child claims to have known in their previous life. Other cases have been known to occur when the child engages in reflective thought (Mills & Lynn, 2000).

From Stevenson's (1987) extensive research of over 2500 cases of PLEs, five major features were revealed. The experience often begins with (1) a prediction of rebirth by the former personality, (2) an "announcing dream" where someone associated with the soon to be born child becomes aware of their intention to be born, (3) a child being born with a birthmark or birth defect corresponding to their 'previous life', (4) the child making statements about their previous life, and (5) the child acting in unusual ways corresponding to the behaviours of their claimed past-life personality. Stevenson indicates that only a small number of people report all five of these features as part of their PLE.

A brief description of a typical case would start with a young child approximately two to four years old, who spontaneously begins to give details about a previous life. They may include information about an individual and their family as well as geographical locations unknown to them in their current life. The clarity and content of these statements typically expand until the child reaches the age five or six. They can often describe events taking place in their alleged previous life as well as the circumstances surrounding their own

death. It is often the case that the means of death of the perceived former personality was violent, often an accident or sometimes murder. In many cases birthmarks or congenital deformities correspond to the cause or circumstances surrounding the death of the claimed former personality. Some children can give details of names and events enabling the identification of a deceased individual whose life corresponds to the child's testimony. Special skills may be displayed or the child may have a phobia, which also correspond with experiences of the child in their claimed past-life. Most children forget these memories by the age of six or seven and stop talking about their alleged past life by the time they are eight (Stevenson, 1987).

4.6.2 Models of the Past-Life Experience

Much of the research investigating PLEs has focussed on recording detailed information given by children about their alleged past lives, as well as the verification of these accounts (Stevenson, 1987). A number of interpretations have been made in an attempt to explain these cases including the afterlife theory of reincarnation, the super-psi hypothesis, the sociocognitive view, the possibility of interviewer or hypnotist's bias, the concept of cryptomnesia, or the presence of psychopathology.

One possible explanation for PLEs is the concept of reincarnation. This idea was widespread in ancient and pre-industrial cultures and formed the basis of a number of spiritual belief systems, including Hinduism, Buddhism, Jainism and Sikhism. The belief in past lives has also been an integral part of a number of other cultures including the ancient Egyptians, American Indians, the Parsees, the Polynesian cultures, and the Orphic cult of

ancient Greece (Grof & Grof, 1991). As well as providing an explanation for the recollection of events in an alleged past life, the reincarnation hypothesis may also be able to explain the occurrence of birth marks and congenital deformities which are not genetically explainable as well as phobias, fears or déjà vu experiences.

Alternative explanations for fears, phobias and déjà vu experiences have been described elsewhere (Mills & Lynn, 2000), but the issue of birthmarks and deformities which are believed to be related to past lives (Stevenson, 1987) will be considered next.

One explanation for the appearance of birthmarks or birth defects holds that trauma-related or intentional marks on the body of an alleged previous personality corresponds to markings on the present individual. In fact Stevenson (1993) has stated that approximately 35% of children who claim to remember past lives possess birthmarks or birth defects which closely correspond to wounds or intentional markings acquired in the alleged past-life. In cases where post mortem or other confirming documents were obtained, approximately 88% of the reported birthmarks or deformities were found to correspond, thus increasing the confidence in accuracy of the child's memory as well as supporting the validity of reincarnation as a possible hypothesis for PLEs (Stevenson, 1993). However, based on these statistics, physical defects provide supporting evidence for about 31% of reincarnation cases. The majority of children (i.e., 65%) did not report birth defects and, with a further 4% of defects not verified, about 69% of children have no direct or corresponding physical evidence of reincarnation.

The evidence for reincarnation and other afterlife theories may not be that strong, based on physical evidence alone, and in fact such theories have been undermined by the super-psi theory (see Braude, 2003; Moreman, 2003). For example, Moreman (2003, p. 412) states that: "Super-psi has long posited the possibility that [raw data in the form of memories] could be transferred between living minds, removing the dead from the equation." Specifically a super-psi theory, which incorporates mystical experiences, can account for the difficulties arising in the traditional person-to-person model of information transference (see Moreman, 2003; see also, Storm & Thalbourne, 2005).

Either way, both theories—reincarnation and super-psi—leave researchers with a paranormal phenomenon that is unexplained in conventional scientific terms. Thus, 'reincarnation-type' cases (Stevenson's, 1975, term) may still relate to a process that facilitates healing and personal transformation.

A further attempt to explain the occurrence of PLEs in children is the sociocognitive hypothesis, based on the notion that social and cultural forces shape children's constructions of their experience. This same cultural bias is thought to influence the interpretation of the child's experience by their parents. If the parents live in a society predisposed to believe in reincarnation they may believe that their child's narratives and experiences are indicative of a PLE, whereas others who do not hold this belief system may attribute the experiences to fantasy (Mills & Lynn, 2000).

This theory also suggests that a child's story may be elaborated upon through questioning, modification of their story by their parents, or if the child's parents meet the family of the perceived deceased person. Schouten and

Stevenson (1998) believe that three further changes may take place: (1) wrong statements might be altered to fit in with new information; (2) statements not previously thought to be related to the PLE may be reinterpreted to fit into newly learnt information; and (3) statements made by the child after meeting the other family may be added to their narrative even though they learnt this new information by ordinary means.

Based on these assumptions, Schouten and Stevenson (1998) believed that a lower percentage of correct statements would be expected if the child's testimony was recorded before the families met. They also believed that the total number of correct, incorrect or unverified statements would be, on average, higher in the cases where statements were recorded after the families met than where they were recorded before the families met. However, research by Schouten and Stevenson (1998)—comparing groups of Sri Lankan and Indian children—found no evidence supporting the hypothesis that the possible avenues described above promote the false elaboration of apparent memories of previous lives or the creation or elaboration of past life memories.

Jürgen Keil and Tucker (2005) provide further evidence challenging the assumption that the PLE is due to false elaboration, by presenting a number of cases where written records have been made of a child's statement before the alleged past life personality has been identified. In particular, they presented a case of a child in Turkey whose statements were found to correspond in great detail to the life of a man who died 50 years before the child was born and lived 850 km away. In such a case there is no possibility of reinterpretation or elaboration.

In another aspect of the sociocognitive view, Spanos (1996) explains how details of the narratives can often be traced back to widely available sources of information, including books, television and other media. Therefore it may be possible that cryptomnesia, a type of amnesia for the source of learned information, may also play a role in this misattribution for the source of PLE information (Mills & Lynn, 2000).

When undertaking investigation into PLEs it is also important to take into account the possible effects of interviewer bias, where the researcher's expectancies and suggestions might somehow influence the children's past-life reports (Mills & Lynn, 2000). Many of the investigations take place in non-western countries and utilise the services of a translator familiar with the language and culture of the interviewee. In this situation it may be difficult for the researcher to assess the possible effects of suggestive techniques of the interpreter or potential bias due to shared cultural beliefs in reincarnation (Mills & Lynn, 2000). In fact, investigations of the reliability and credibility of young children's reports by Bruck, Ceci and Helmbrooke (1998) have found that interviewer bias plays a large role in suggestive interviews with children.

In a similar way to interviewer bias, it may be possible for other techniques such as hypnosis to influence the narrative of a past-life report. Possible influences from the hypnotist are important to acknowledge as hypnosis plays a large role in past-life regression therapies which are often used in the retrieval of information from presumed past-lives (Mills & Lynn, 2000). Spanos (1996) reviewed past-life regression therapy research with people reporting somatic symptoms thought to be connected to their past lives. He concluded that these individuals constructed past-life fantasies which were

congruent with their symptoms and therefore their reports were accepted as evidence for the reality of their past-life. Spanos, Menary, Gabora, Dubreuil and Dewhirst (1991) further indicated that the extent to which the subjects believe in their past-life fantasies depends on the support of a significant other, often the therapist, believing that their experiences are real, their prior beliefs in reincarnation, and their expectations while recalling a past-life.

4.6.3 The Past-life Experience and Psychopathology

The spontaneous recall of alleged past-life memories has not been linked to psychopathology in childhood or adulthood (Lynn & Mills, 2000). In fact, research has indicated that after the age of ten, children reporting PLEs continue to develop normally (Stevenson, 1987). There have been some differences recorded in the psychological performance between children identified as having a PLE and their peers, although the results have varied from study to study (Haraldsson, 2003). Summarising his previous research, Haraldsson (2003) indicated that PLEers generally displayed a greater vocabulary and understanding of language, showed improved school performance, a greater capacity for recent memory, spent more time daydreaming and showed scores on brief intelligence tests higher than their peers. Haraldsson's (2003) research also indicated that in comparison to their peers children who claimed memories of a previous life differed in a number of psychological traits, including being more argumentative, having a richer fantasy life, being more fearful as well as displaying higher levels of perfectionism, nervousness and dissociative tendencies but not being more suggestible or socially isolated.

Strong signs of fear, anxiety, and aggressiveness in the PLE group indicate that they may be traumatised and that the demands for attention shown by many of the children may be a sign of distress. Haraldsson's research showed no indicators of child abuse but he speculated that the trauma might be found in the reported images, as approximately 75% of the children reported experiencing a sudden and violent death. No suggestions were offered for the cause of trauma experienced by the 25% of children who did not report memories of a sudden or violent death.

Given that when speaking about their alleged past life these children often talk about themselves as having a different personality, it is appropriate to explore whether these children have psychological traits in common with individuals diagnosed with dissociative identity disorder. Although Haraldsson (2003) found that the PLE group obtained higher scores on dissociation than their peers, the level of dissociation was much lower than individuals diagnosed with dissociative identity disorder.

In contrast to these studies in which spontaneous PLEs were investigated, Spanos (1996) believed that past life personalities created during past life regression therapy are an experimentally created form of multiple personality identity which are contextually generated, rule-governed goal directed fantasies, constructed to meet the demands of the hypnotic regression situation. He believes that the information used to construct the reports is readily available to the individual, thus supporting the socio-cognitive hypothesis mentioned above.

4.6.4 The Past-life Experience as Spiritual Emergency

Past-life experiences include a number of elements considered by Grof and Grof (1989, 1991) to constitute a spiritual emergency. They believe that when the PLE material is close to conscious awareness it can have a profound impact on the individual, leading to serious physical and emotional distress. The individual may experience unusual sensations in various parts of their body including sharp pains or feelings of suffocation for which they can find no medical explanation. They may also experience irresistible attractions or unsubstantiated fears of certain people, situations or places. At times, images of unknown faces, scenery or objects may emerge into consciousness.

When the PLE material emerges into conscious awareness in the midst of everyday activities another set of difficulties may arise. The individual may feel a strong urge to act out certain aspects of their PLE, which may interfere with their normal functioning or cause unrest in their relationships with others who have no understanding of the basis for their behaviour. Once the inner process comes to an end, an additional challenge often arises. While some individuals may readily accept their unusual experience, others may find it difficult to integrate their PLE into their belief system or understanding of reality (Grof & Grof, 1989, 1991).

Grof and Grof (1991) believe that the PLE holds great potential for healing and transformation regardless of whether or not it supports the theory of reincarnation. They believe that previously incomprehensible aspects of one's personality can become understood as karmic carryovers from a previous lifetime. This may explain certain unsubstantiated fears, strong attractions or repulsions, difficulties in relationships with certain people, as well as

unusual emotional or psychosomatic problems. Grof and Grof believe that after a powerful PLE, many individuals experience the alleviation or complete elimination of various problems which conventional treatments were unable to cure.

4.6.5 Summary

There have been many reports from people around the world who claim to have memories of living a previous life. Many of these reports come from young children in cultures holding a belief in reincarnation, although there are also growing numbers of reports from adults and children elsewhere. A number of individuals have provided extensive narratives including information about their alleged past-life personality, their family, their living situation and their means of death. Some of this information has been verified by past-life researchers.

Theories discrediting the possibility of a past-life, claim that such causes as interviewer bias, super-psi or socio-cognitive influence, may explain the phenomenon, although to date there is no theory which can account for all aspects of the PLE. In particular, almost a third of the children claiming to recall a past life have birth defects or birthmarks that correspond to the cause or circumstances surrounding the death of their alleged past-life personality, and all of these have been verified by medical records.

Deficits in cognitive development have not been found in children claiming past lives, and some research has indicated that the PLE can be a positive experience facilitating healing and personal transformation. The literature gives no evidence that individuals claiming past-life memories are

mentally ill. If these individuals are indeed somehow accessing information from a past life this would prove reincarnation, a concept accepted in many cultures around the world. This type of phenomenon seriously challenges the concept of reality currently shared in western culture, and needs to be critically evaluated in order to gain a better understanding.

4.7: THE NEAR-DEATH EXPERIENCE

4.7.1 The Near-Death Experience

Raymond Moody's (1975) investigation of the NDE included personal reports from 150 individuals who were resuscitated after being pronounced clinically dead or who came close to physical death due to illness, accident or severe injury. From his interviews, Moody (1975) discovered that the NDE is often precipitated by a moment of great physical distress, after which the individual finds themselves out of their physical body. Some may hear an uncomfortable ringing or buzzing noise followed by a feeling of great peace. The individual may find themselves outside their physical body, watching the accident scene or resuscitation attempt from above, or travelling to distant locations. Some will hear a doctor pronounce them dead. A person may move rapidly through a dark tunnel which leads to a source of radiant light or supernatural beauty radiating all-embracing, love, acceptance and forgiveness. Here one glimpses spirits of deceased friends and relatives who have come to meet and guide them. The individual may share a personal exchange with a being of light, concerning profound lessons of life and universal laws, in order to assist them to evaluate their life. The individual may

see a panoramic playback of major events throughout their life within seconds of ordinary time. At some point the individual approaches an impassable barrier, which seems to represent the limit between earthly life and the next, and they find that they need to go back as it is not yet their time to die. Some may resist, as they are attached to their new experience and are overwhelmed by intense feelings of joy, love and peace. Despite this resistance, the individual returns to the physical body and although they try to tell others of their experience, they can find no words to do so adequately. The experience profoundly affects their life, alters their views about death and its relationship to life, and individuals often make changes in accordance with the new principals they have learnt.

Moody (1975) indicates that no two accounts are the same, no one reports every component of the composite experience, there is not one element that has been reported by each person, each element shows up in a number of accounts, the order of experiences may vary from person to person, people who are reported “dead” for a longer time generally report more florid and complete experiences and some people report none of these elements. Since this initial research, there has been a growing number of verifiable accounts of adults and children worldwide reporting a series of events taking place after they have been pronounced clinically dead by a medical practitioner. This increase may be due to recent advances in medical technology (van Lommel, van Wees, Meyers & Elfferlch, 2001) as well as the breakdown in social taboos concerning discussion on death.

Further investigation by Ring (1980) confirmed much of the phenomena reported in Moody’s research, but revealed a “core” experience

made up of five distinct stages, each unfolding in a characteristic way, with the earlier stages of the experience being more common than the later stages.

Greyson (1985) described the NDE as being made up of a number of cognitive elements, affective elements, paranormal elements and transcendental elements. Although not all NDEs included all of these features, Greyson found that each individual NDE could be classified as belonging predominantly to one of these groups, thereby making it easier to research each of these features separately. In Greyson's classification system the cognitive component includes time distortion, thought acceleration, life review, and sudden understanding; the affective component includes feelings of peace, joy, cosmic unity, and an experience of a brilliant light; the paranormal component includes enhanced vision or hearing, apparent extrasensory perception, precognitive vision, and out-of-body experiences; and the transcendental component includes encounters with an unearthly realm, a mystical being, visible spirits and a barrier or "point of no return", that if crossed precludes the return to life.

The NDE has been reported to occur in more than one third of people who have come close to losing their life (Grof & Grof, 1991) and although slight variations have been found between individuals nearing death by illness, accident or suicide, the core NDE tends to remain the same (Ring, 1985). Ring's research also revealed that the likelihood or depth of a core NDE does not seem to be significantly related to social class, race, marital status, age, sexual orientation, economic status, religious affiliation, religiousness or prior knowledge of NDE phenomena, indicating that the NDE is a relatively robust phenomenon.

A literature review by Ring and Elsaesser-Valarino (2000) indicated that the NDE is not only a revelation of profound and soul-shattering beauty, but it also has the power to bring about lasting changes in one's personal values and beliefs. After the NDE, the individual often has an increased appreciation of life, experiences increased feelings of self-worth, has a more compassionate regard for all life, develops a heightened ecological sensitivity and reports a decrease in materialistic and self-seeking values. Religious orientation changes and tends to become more 'spiritual' in expression and the fear of death is often overcome and replaced by a deep-rooted conviction that there is some form of afterlife. It is claimed that many individuals also develop powers of higher sense perception, increased 'psychic' ability, intuitive awareness and the gift of healing.

In a retrospective review of NDE data received via an internet survey for the Near Death Experience Research Foundation (NDERF), it was reported that 75.79% of NDErs experienced changes in attitudes or beliefs after their experience while 10.38% of NDErs experienced no changes in attitudes or beliefs after their NDE. "Life changes" were also recorded with 58.18% of NDErs reporting life changes as a direct result of their NDE, while 11.95% of NDErs reported experiencing no life changes as a result of their NDE (Long, 2007).

A significant increase in the belief of an afterlife is often reported following an NDE (Ring, 1980; Sutherland, 1992). In fact, many people who previously expressed a disbelief in the afterlife, through their experience have become convinced in life after death (Sutherland, 1992). Although most reported NDEs include profound feelings of peace, joy, and cosmic unity,

there have also been reports of unpleasant, frightening, or hellish experiences (Greyson & Bush, 1992).

The incidence of these distressing experiences have been estimated to range from 1-15% of NDErs (Bonenfant, 2001), indicating that it is either a rare phenomena or those who have a negative NDE choose not to report it. Further, no connections have been found between the means of coming close to death (Ring, 1980), the behaviour, attitudes, beliefs or history of the NDEr and the likelihood of them having a negative NDE (Bush, 2006).

Distressing NDEs tend to fall into three distinct categories. The first includes similar experience to the peaceful NDE's, but are interpreted as unpleasant. The second consists of a sense of non-existence or eternal void, and the third consists of graphic hellish landscapes and entities.

Current scientific research into the NDE tends to follow two distinct paths. Some see the NDE as proof that consciousness can detach from the physical body and lends toward to the possibility of an afterlife. Another group of people interpret the NDE phenomena as a part of life, possibly an anomaly of the brain, with no hint toward the possibility of an afterlife. However, an operation on a brain dead individual (Pam Reynolds) provides evidence to the contrary. This operation required that the patient's body temperature be lowered to 60 degrees, her heartbeat and breathing stopped, her brain waves flattened, and the blood drained from her head. In everyday terms, she was put to death. After removing the aneurysm, she was restored to life. During the time that Pam was 'dead', she experienced an NDE. Her remarkably detailed veridical out-of-body observations during her surgery were later verified to be very accurate. This case is considered to be one of the

strongest cases of veridical evidence in NDE research, as Pam was able to accurately describe the unique surgical instruments and procedures used during her operation as well as other events taking place while she was clinically and brain dead (Williams, 2005, cited in Storm, 2006a, p. 295).

With such verifiable evidence it would be difficult for a sceptic to dismiss these phenomena as hallucinations, superstitions, modern myth, or even explain it away scientifically by various scientific or neurophysiological theories. However, given that these events do not fit into our current scientific paradigm, it is important to continue the exploration of NDE phenomenon until we find a model that can accommodate all aspects of the experience.

4.7.2 Models of the Near Death Experience

This section presents a number of commonly cited explanations appearing in the NDE literature including the temporal lobe theory, cerebral anoxia, the role of anaesthetics, and the NDE as a mystical experience.

Support for a temporal lobe theory of the NDE began when Canadian neurosurgeon, Wilder Penfield (1955), directly stimulated various regions of the temporal lobe, eliciting reports of various phenomena from his patients. These included feelings of vertigo and leaving one's body, hallucinations, various motor responses, hearing pieces of music, remembering whole blocks of memories, as well as the sensation of actually reliving certain memories. Although distorted perceptions, feelings of fear, sadness and loneliness were also elicited from temporal lobe stimulation, these are not generally characteristic of the NDE. Nonetheless, these findings prompted further

research for a neuro-physiological explanation of the NDE implicating the temporal lobes and implying that the NDE takes place entirely in the brain.

More recent research using external electrical stimulation has supported the involvement of the right temporal lobe in NDE-like phenomena (Persinger, 1987) although it has been suggested that the right temporal lobe may play a mediating role for spiritual experience (Morse & Perry, 1992) rather than reducing the NDE to the outcome of abnormal brain activity in the temporal lobe.

It is widely known that the use of anaesthetics is occasionally associated with phenomena similar to the NDE. However, Moody (1975) believes that hallucinations resulting from anaesthetic use differ from NDEs as they are generally unclear and reveal inconsistencies between accounts. Sabom's (1982) research indicated that medicated patients reported fewer and less elaborate NDEs compared to patients who remained drug-free during their experience. In addition, Ring (1980) revealed that drug usage tends to be negatively associated with the NDE experience and people who have encountered both drug-induced hallucinations and an NDE can distinguish between the two (Sabom, 1982). Overall, the NDE research does not support the suggestion that the NDE is a product of drug use, as many reports come from children or adults who were not under the influence of drugs at the time of their NDE.

Another frequently cited physiological model attributes NDEs to cerebral anoxia, deprivation of oxygen supply in the brain. So in effect, most people who have been clinically dead should experience an NDE. However, van Lommel, et al. (2001) investigated NDEs among patients who were

brought back from cardiac arrest and they found that 18% reported a NDE. They concluded that if purely physiological factors resulting from cerebral anoxia caused the NDE, most of their patients should have experienced a NDE. Sabom's (1982) research indicated that individuals who have experienced an NDE do not show lower oxygen levels than those who have been near death and didn't have an NDE. In addition, anecdotal accounts of people watching attempts at resuscitation while in the out of body state, at times report back their experience in great detail, which is not indicative of the semiconscious state of anoxia (Sabom, 1982).

Many features of the NDE are similar to those of the mystical experience. Pennachio (1986) used the nine-category typology of mystical experience identified by Walter Pahnke, to illustrate the mystical nature of the NDE. These shared features include (1) a sense of unity, (2) transcendence of time and space, (3) feelings of peace and love, (4) a sense of sacredness, awe and wonder, (5) feelings of insight or illumination, (6) paradoxicality, (7) ineffability, (8) transiency and (9) the persisting positive changes in attitudes and behaviour toward oneself, others, life, and the mystical experience itself. Greyson (2006) believes that the most important attribute common to both the NDE and mystical experience is the personal transformation following the experience, including significant changes in values and attitude toward death, and a new sense of purpose or meaning in life. It is interesting to note that the transformative aspects of the NDE differ from those who experienced induced NDEs (van Lommel et al., 2001) as well as those who came close to death, but did not experience a core NDE (Ring, 1980). Ring (1985) also proposed the possibility that the NDE may be a catalyst for movement toward a higher

level of consciousness and this shift in consciousness can be explained using the holographic model³⁵ (Ring, 1980). Although there have been a number of scientific theories proposed for the NDE, to date, even the most complex models for NDEs cannot explain all of the associated phenomena.

4.7.3 The Near Death Experience and Psychopathology

Although many individuals experience a variety of positive changes in their life in the aftermath of their NDE, one can also encounter difficulties connected to the interpretation or integration of their NDE into everyday life. The NDEr may also experience difficulty reconciling their new attitudes and beliefs with their previous beliefs, as well as those of family and friends, which may interfere with maintaining one's old roles and lifestyle (Greyson, 1997).

Despite their own certainty of the reality and the importance of what has happened to them, many individuals are afraid to share their NDE, for fear of being ridiculed, rejected, labelled as crazy, hysterical or psychotic by their doctor, family or friends (Moody, 1977). One person declared, "I tried to tell my nurses what had happened when I woke up, but they told me not to talk about it, that I was just imagining things", and another, "I tried to tell my minister, but he told me I had been hallucinating, so I shut up" (Moody, 1975, p. 82). It has been acknowledged that the way others respond to one's NDE can influence whether the NDE becomes a stimulus for further growth or whether it is dismissed as an odd experience, not to be shared, for fear of being labelled mentally ill (Greyson, 1997).

³⁵ The theory behind the holographic model was conceived independently by quantum physicist David Bohm and neurophysiologist Karl Pribram. The model holds that the entire universe is a hologram and is allegedly able to explain a wide range of phenomena, which until recently lay beyond scientific understanding (Talbot, 1996).

The NDE can cause a variety of emotional problems including anger and depression, especially in regard to returning to the physical dimension (Greyson, 1997). Some individuals may become so distressed that they fulfil the criteria for an adjustment disorder. However, as these symptoms occur so frequently, they must not be considered as excessive reactions, but as a normal response to the NDE (Lukoff, Lu & Turner, 1998). Individuals, especially those who had a negative NDE, may also report similar symptomatology to those experiencing PTSD. These may include recurrent, intrusive recollections of the event, a feeling of reliving the experience, recurrent distressing dreams of the event, psychological distress and physiological reactivity to exposure of symbolic cues, avoidance, diminished interest in activities, estrangement from others, restricted range of affect, and a sense of foreshortened future (Greyson, 1997).

Survivors of life-threatening danger often report features of depersonalisation including alterations in the experience of time and space, a sense of detachment, a lack of emotion, panoramic memory, clearer vision or hearing and a feeling of non-reality (Noyes & Kletti, 1977). These subjective effects are believed to be a defense against the threat of extreme danger or its associated anxiety. As some NDEs share a range of these features, Noyes and Kletti (1977) considered the NDE as a type of depersonalisation. Greyson's (2000) research indicated that people exposed to an NDE reported significantly more dissociative symptoms than a non-NDE group, but the level of the symptoms was substantially lower than that of patients with pathological dissociative disorders. In addition, the pattern of dissociative symptoms reported by people who have had NDEs is consistent with a non-pathological

dissociative response to stress, and not with a psychiatric disorder.

Depersonalisation also fails to account for many elements of the NDE, including the accompanying spiritual and mystical feelings, as well as reported increased levels of alertness and awareness (Noyes & Slymen, 1978).

4.7.4 The Near-Death Experience as Spiritual Emergency

Rather than being a sign of psychopathology, NDEs can be seen as powerful catalysts for spiritual awakening and consciousness evolution (Grof & Grof, 1991). In fact, Grof and Grof (1991) indicated that the profound changes in personality resulting from the encounter with the “being of light” are similar to the changes made following the spontaneous peak experiences described by Maslow. Ring and Elsaesser-Valarino (2000) also believe that the NDE appears to promote a type of functioning suggestive of a highly developed human being and suggests that NDErs and others who have undergone similar awakenings may be the harbingers of humanity's evolution toward higher consciousness.

The profound changes in the individual after the NDE would seem to indicate a gradual unfolding of a greater spiritual awareness. However, it can also lead to a psychospiritual crisis. A possible reason for this is that the profound shift in the experience of reality caused by the NDE often occurs abruptly, without warning to the individual who is totally unprepared for the event (Grof & Grof, 1991). In this instance, one may find it difficult to grasp an understanding of their experience and may worry that they are somehow abnormal. Or, they may find it impossible to communicate the magnitude of

their experience as well as the impact that the NDE has had on their lives (Greyson & Harris, 1989).

As with other types of spiritual emergencies, the individual experiencing a NDE is exposed to dimensions of reality ordinarily hidden to human perception. Although they may have been profoundly transformed by their experiences, they continue to live in a culture whose worldview they no longer share, which increases the possibility of emotional, intellectual and spiritual crisis (Grof & Grof, 1991).

4.7.5 Summary

There has been an increase in reports from individuals, around the world, experiencing a series of extraordinary phenomena occurring when they are near, or at the point of physical death. These experiences tend to promote a profound and lasting positive transformational change in the individual, prompting them to live a more harmonious life in line with their new understanding of reality. Following their NDE, many individuals, including those who previously expressed a disbelief in the afterlife, have become convinced of life after death.

Current research has indicated that the NDE is a universal phenomenon not limited by age, culture, religious or social backgrounds, and to date, even the most complex models for NDEs have not been able to account for all of the associated phenomena. Some researchers see the NDE as proof that consciousness can detach from the physical body and believe this lends support toward to the possibility of an afterlife. Others interpret the

NDE phenomena as a part of life, possibly an anomaly of the brain, with no hint of the possibility of an afterlife.

In Moody's (1975) original investigation of 150 NDEs, there was only one case where the attending doctor had any familiarity with NDE phenomena. With an increase in the reported number of NDEs and scientific research into the phenomena, it is possible that this situation has changed. However, it is important that emergency workers have an understanding of the enormous psychological and spiritual implications of the NDE, regardless of the scientific theories surrounding the phenomenon. If attempts are made to understand the NDE and how the events taking place within the experience can change one's worldview, it would be more likely that the NDEer is able to integrate their experience and use it as a catalyst to make long-lasting positive changes in their lives.

4.8: SPIRIT POSSESSION

4.8.1 The Experience of Spirit Possession

Harper's Encyclopaedia of Mystical and Paranormal Experience has defined "possession" as a "...taking over of a person's mind, body and soul by an external force perceived to be a deity, spirit, demon, entity or separate personality" (Guiley, 1991, p. 457). Extensive research by Grof and Grof (1991) has also indicated that a "possessed" individual feels as though their body and psyche are being invaded and controlled, usually by a hostile and disturbing energy with personal characteristics distinct from their own personality. The "possessed" state manifests in various forms. It may be

persistent or irregular and can vary in degrees of intensity. The “alien energy” may remain latent, causing a number of symptoms with unknown aetiology, or it may come close to the surface, where the “possessed” individual is aware of its presence and may need to exert a huge amount of energy to stop it from becoming manifest.

During Grof and Grof’s (1989) experimental therapy sessions, a variety of physiological changes often become manifest in the bodies of “possessed” individuals. Faces can take on wild and terrifying expressions; bodies can develop severe cramps, spasms and strange contortions; the voice may become altered taking on another quality, activity may become frantic, one may lose control and experience dramatic episodes of choking or vomiting. The Grofs indicated that these behaviours have also been observed during exorcisms in indigenous cultures as well as those occurring within the Catholic Church.

“Spirit possession” is closely associated with altered states of consciousness, usually some form of trance state. Some Shamanic practitioners voluntarily induce these trance states through suggestion, dance and drumming, for the purposes of acquiring individual power (Bourgignon, 1976). It is believed that this Shamanic ASC is caused by “spirit possession” and the entity is said to take control of the “possessed” individual’s body as well as “replace” the individual’s personality (Bourguinon, 1989). It is believed that the “Divine” has become manifest when the Shaman shows visual signs that a spirit has entered his/her body. During this time, it is said that the Shaman’s ego detaches from the body to make room for the intruding spirit and the Shaman allows the experience to run its course without any

interference. He or she is able to exit these states, at will on their own, or with the help of assistants, and usually retain no memory of their experience. The varying “possession” states traversed may last from a few minutes to half an hour. It is said that most Shamans pass through a series of alternate states of varying depths of experience during one session, until they reach the level of which they operate best (Heinze, 1991).

Examination of a variety of “possession” experiences by Cardefia (1989, cited in Heinze, 1991), led him to differentiate between three distinct states of “possession”. First, the transitional state, consisting of dizziness or light-headedness, disturbances in equilibrium, somatic alterations and cognitive disorganisation. The second state involves a discrete identity, the change of one identity to another, co-identities as well as unusual behaviours and experience. The third state includes transcendent qualities, such as consciousness expansion, a total involvement in the experience and an alternate modality of experiencing the world.

4.8.2 Theories of Spirit Possession

This chapter presents three arguments, which attempt to explain the nature of “spirit possession”. First, as outlined in the previous section, is the idea that spirits exist and can possess an individual, causing them to act in certain ways. This idea has been embraced by recent anthropological research. Explored in the following section are also a number of psychological explanations that see “spirit possession” as (i) spirit obsession (Swedenborg, 1952; Van Dusen, 1985); (ii) archetypal identification (Jung, 1959b); (iii) a culturally shaped altered state of consciousness (Castillo, 1994a), and (iv) a

contributing factor of mental illness (Gadit, 2007; Grof & Grof, 1989, 1991). Finally, explored in the next section, is the idea that “spirit possession” is the result of some kind of psychopathology.

Van Dusen (1985), a clinical psychologist, conducted extensive interviews with individuals who were experiencing hallucinations. His initial dialogues revealed that these individuals objected to the term ‘hallucination’, as they believed they were in contact with other people from another world. From these dialogues with the individuals and the entities believed to inhabit these individuals, Van Dusen learnt of the ‘higher’ and ‘lower’ orders. The lower order seemed imprisoned in the lowest level of the person’s mind, they illuminated the person’s weaknesses, had a persistent will to destroy, showed low intelligence, were repetitive and not open to real dialogue. Swedenborg (1952), who also wrote extensively on these two orders, explains that excessive self-interest and a lack of ethical position can open the psyche to allow “possession” by the lower order. In contrast, the less frequently appearing higher order appeared in non-interfering ways, could communicate directly with the inner feelings of the individual, was genuinely supportive, and provided meaningful inner guidance.

These hallucinations are similar to what Swedenborg called obsessions, where the spirits occupy our will and understanding and we find ourselves caught in false ideas. And it is through our own choice, albeit severely impaired by the ‘invasion’, that we carry these ideas through to our bodies into action (Swedenborg, 1952). Van Dusen (1985) also found similarities between the higher order and Jung’s archetypes, and between the lower order and Freud’s concept of the id.

Jung (1959b) believed that “possession” is a phenomenon produced when a complex takes over the functioning of the ego. This will most often occur when the individual unconsciously succumbs to the influence of the archetype, which already holds a certain position of autonomy. Baldwin (1991) also believes that entities function on the level of the subconscious mind, rarely making their presence known to the individual. As the entities are functioning on the subconscious level, the attitudes and behaviours of these entities often become indistinguishable from the possessed individual’s own thoughts and actions.

Castillo’s (1994a) extensive research on “spirit possession” in South-East Asia revealed that some anthropologists consider “possession” as a culturally shaped altered state of consciousness. Castillo believes that it was Erika Bourignon who first suggested that “possession” is a universal phenomenon, with similar experiences occurring within many belief systems around the world. She claims that consciousness is not only a product of personal and social programming but also contains several universal features, which remain the same regardless of race or heredity. Castillo (1994a) believes that this theory of “spirit possession” relies on socio-cultural research and takes into consideration the possibility of mental illness or other underlying psychological processes.

Some psychiatrists recognise “possession” as a significant contributing factor for certain types of mental illness that cannot be explained within the sociological, psychodynamic, psychological or psychiatric frameworks (Gadit, 2007). Grof and Grof (1989, 1991) believe that “possession” can be the driving force behind certain types of serious psychopathology including some

forms of antisocial or criminal behaviour, excessive consumption of alcohol and drugs, self-destructive tendencies or atypical sexual impulses. They believe that the "possessed" individual must be exposed to psychotherapeutic methods, which activate the unconscious mind, in order to identify the underlying cause of these problems.

Stafford (2005) explains that potential arguments against the "spirit possession" hypothesis centre on our current-day disbelief in spirits, our understanding of dissociative identity disorder (DID) and the effectiveness of medication to relieve some of the symptoms of "possession". However, Stafford also stresses the importance for psychiatrists to examine their materialistic understanding that mental illness is the consequence of an aberrant brain and investigate why exorcisms are often successful where psychiatry has failed. In support, Gadit (2007) who is a professor of psychiatry, believes that it is inappropriate for conventional science to refute something that science cannot prove given our limited understanding of the world.

4.8.3 Spirit Possession and Psychopathology

A further explanation, maintained by the mainstream medical community, would diagnose an individual displaying "possession" like symptoms as having some kind of mental illness. According to Mizrach (2007) this idea began with the early natural 'scientists' who suggested that "possession" might be a state of mental disturbance rather than the expression of some outside spiritual force, which was the general consensus at the time. These 'scientists' noted various similarities between the behaviour of possessed individuals and the fits and convulsions of those suffering from

epilepsy and psychosis. Therefore they suggested that these possessed individuals might be mentally ill and believed it would be best to confine them to asylums. It was also observed that the possessed state occurred more often in females than males, and the condition began to be diagnosed as 'hysteria', an irrational emotional response believed to be caused by unresolved Oedipal desires (Castillo, 1994a).

Gadit (2007) listed a number of symptoms frequently attributed to "possession", including hallucinations, antisocial behaviour, agitation and seizures, voice changes, alleged ability to predict the future, ability to talk in a previously unknown language and a marked increase in physical strength. "Possession" shares some of these symptoms with a number of psychiatric illnesses including schizophrenia, various other psychotic disorders and DID, formerly known as multiple personality disorder (MPD).³⁶

Individuals afflicted by DID experience two or more distinct personality states, which repeatedly take control over the person's behaviour, contributing to impaired recall of personal information (DSM-IV-TR, 2000). Stafford (2005) indicates that the primary personality of the individual experiencing DID may not be aware of the secondary personality, or "alter". When the "alter" surfaces, it is said to have a life of its own, often strikingly unlike the primary personality. According to Stafford, many psychiatrists believe that the "possession" state is one where the "alter" has displaced the primary personality. Castillo (1994b), however, believes that there is a distinct difference between "spirit possession" and DID. In DID, the primary personality is usually oblivious to the existence of an "alter", whereas in

³⁶ For the sake of consistency, "dissociative identity disorder (DID)" will be used even for papers that previously used "multiple personality disorder (MPD)".

“possession” the individual is often aware of the self-destructive alien personality.

Although Klass (2003) believes that “possession” takes place when a subordinate consciousness takes over a superordinate consciousness, he does not believe that this is necessarily indicative of pathology. In his extensive research on “spirit possession” and DID, Klass explains that within psychology and psychiatry, dissociation is usually linked with psychopathology; however within anthropology, it is generally agreed that the majority of cases are not associated with mental illness. Castillo (1994a) adds that the phenomena experienced in the dissociated state may be considered pathological depending on which behaviours and experiences are considered appropriate in the prevailing culture. He explains that each culture has its own types of mental illness. Symptoms or clusters of symptoms may overlap with those in other cultures. However, generally the signs and symptoms, treatment and outcomes are largely determined by “culture-based cognitive categories”.

Research on culture-bound syndromes (CBS) has examined the differences between what constitutes mental illness and what may be a culturally specific set of beliefs and practices, employed to cope during difficult circumstances (Simons, 2001). For example, serious sickness, including those affecting the mental health of indigenous Australians, is often attributed to external forces or an external culturally based wrongdoing, which can result in the expression of symptoms similar to those of psychopathology (Westerman, 1997, 2000; cited in Vicary & Westerman, 2004). For some indigenous Australians, wellness incorporates a broad range of personal and

environmental factors making wellness both a holistic and ecological concept. “Weakness” in wellness can be seen to predispose an individual to illness, the onset of which is believed to further reduce wellness, allowing the possibility of malevolent “spirits” to influence an individual’s behaviour (Vicary & Westerman, 2004). Simons (2001) believes that we need to question whether culture-bound syndromes are best examined within the western psychiatric model, or more appropriately explained within an anthropological framework.

It is important to acknowledge that recent changes in the DSM-IV, reflecting the need to be more culturally sensitive, do not consider episodes of “possession” as pathological if the prevailing culture accepts the belief and it poses no limitations on the life of the individual (DSM-IV, 1994). This can be clearly illustrated when looking at “possession” in the South East-Asian context, where Castillo (1994b) believes there are two major factors influencing how “possession” will be perceived. In the first instance, “possession” will be classified as “possession” if the possessing entity is understood to be a “supernatural being” such as a ghost, a demon, or a God. However, if the possessing entity is believed to be a “human personality”, the individual will be often be diagnosed with DID. Castillo makes it clear that although “spirit possession” and DID are parallel trance-related disorders, they are psycho-culturally distinct and can be differentiated from each other.

It is important that “spirit possession” be differentiated from psychopathology to ensure correct care and treatment for the afflicted individual. Currently, within the western scientific literature, the treatment of “possession” has produced mixed results. Gadit (2007) explains that some individuals believed to be possessed by spirits experienced reduction in

symptoms after treatment with neuroleptic medication. However, he maintains that other individuals with similar psychiatric diagnosis did not respond well to medication, but benefited from various Shamanic treatments. Finally, Peck (1983), a psychiatrist in the US who participated in two exorcisms, maintains that exorcism is an effective cure and in certain situations, the only effective cure for the possessed individual.

4.8.4 Spirit Possession as Spiritual Emergency

Although “possession” is often associated with highly destructive forms of behaviour and involves “negative energies”, Grof and Grof (1989, 1991) believe that “possession” clearly belongs in the category of spiritual emergency. They believe that the so called demonic archetype, which is said to represent the polar opposite or negative mirror image of the divine, is at the root of the “possession” experience and is clearly transpersonal in nature. The Grofs also believe that the “possession” state functions as a screen, concealing access to the profound spiritual experience, which often follows the successful resolution of the “possession” state (see also, Stevens, 1994, where the parallels between Jung’s Shadow archetype and Grof and Grof’s ‘demonic’ archetype are evident).

The actions of the individual during their “possession” state can be disturbing for both the individual and outsiders. When the “possessed” individual becomes aware of an entity’s presence, they may spend an enormous amount of effort to control its actions in order to prevent it from becoming manifest. If the individual’s usual defence mechanisms fail, a crisis may spontaneously occur in the midst of everyday life and

the individual may become even more frightened and isolated as they watch their family, friends and caregivers withdraw. Upon the manifestation of the “possession” state, outsiders have been known to respond with a mixture of fear and moral rejection, and have labelled the “possessed” individual as evil and refused further contact. Grof and Grof (1989, 1991) believe that a positive therapeutic environment supporting the individual to confront and express the disturbing energy will facilitate the extraordinary healing and transformational potential of the experience.

Bourgignon (1976) also believes in the positive transformative potential in some forms of “possession”. She makes a distinction between voluntary and involuntary “spirit possession”. If an individual becomes involuntarily possessed, it often has negative consequences for the individual and those around them, and an exorcism is often employed in order to dislodge the spirit. In voluntary “possession”, the individual chooses to become possessed, the “possession” usually lasts for a limited amount of time and the individual believes that they will somehow benefit from the “possession” state. It is understood that an individual who willingly becomes possessed must have good health and a sound mind to do so (Heinze, 1991), thus negating the likelihood of mental illness.

As with all spiritual emergencies, it is important to determine whether an individual is experiencing some form of mental illness or a type of psycho-spiritual crisis. Cook (2007)³⁷ believes that “possession” and mental illness are not mutually exclusive diagnoses, but that “possession” may actually be a causative factor in some psychopathology. Within psychiatry it is recognised

³⁷ (http://www.meta-religion.com/Psychiatry/Demonic_possession/dp_and_mental_illness.html)

that mental illnesses are of multi-factorial aetiology, involving the physical, social and psychological components and Cook believes that in order to maintain a truly holistic view of the human condition it is important to take the spiritual dimension into consideration. He affirms, as does Jung (1959b), that “possession” is fundamentally a spiritual problem and spiritual insight is of great importance in assisting the differentiation between “possession” and mental illness.

Within communities where possessed individuals are honoured and entrusted with the ability to heal, the community members are able to clearly differentiate between the “possession” state and mental illness (Klass, 2003). If so-called “spirit possession” exists in our society as it does in others, it is important that the medical profession gains a clear understanding of “possession” so that it may be distinguished from mental illness and so that appropriate treatment may be put into place.

4.8.5 Summary

The concept of “spirit possession” has existed throughout history, and still remains an integral part of some indigenous communities today. Within the western medical model “possession” is not normative and is often diagnosed as a dissociative or psychotic disorder, leading to psychiatric treatment and possible hospitalisation. Some researchers believe that “possession” may be (1) the expression of a hidden aspect of the individual’s personality, (2) an underlying factor in mental illness, (3) a spirit attachment, or alternatively (4) a culture-based syndrome. As psychiatry itself is established within culture-bound categories of experience, it is difficult for

mental health professionals to remain unbiased in their diagnosis. We must once again refrain from imposing our western cultural and diagnostic categories and psychopathologise something that has received so little unbiased scientific research.

It is clear that further research needs to take place in order to understand the underlying mechanisms of the “possession” state. Conventional science may have something to learn from a number of indigenous societies that have successfully used the “possession” state as one of healing for hundreds of years.

4.9: PSYCHOLOGICAL RENEWAL THROUGH RETURN TO THE CENTRE

4.9.1 General Introduction

It is believed that archetypal images are primordial patterns and form the basic content of religions, mythologies, legends and fairy tales of all ages. Archetypes are perceived and experienced subjectively through these universal mythological motifs and images as well as emerging from the collective unconscious. These images can arise in dreams and visions, during times of deep psychological analysis, profound subjective experience, or during episodes of mental illness. An encounter with archetypal images has a strong emotional impact, conveying a sense of divine power, which transcends the individual ego and often leaves the individual in a state of transformation (Edinger, 1986).

The archetype representing the centre, the central archetype or the Self, expresses psychic wholeness and totality (Jung, 1959a,b). During the

activation of this archetype there is a flooding of dramatic, disturbing and ecstatic imagery into the conscious awareness of the individual. The initial part of this process is often chaotic and confusing but when it is allowed to proceed through this stage, the experiences gradually move toward healing and restoration (Perry, 1990).

Throughout his work with individuals in non-ordinary states of consciousness, Perry (1990) found a predictable pattern of imagery that he termed the “renewal process”. Perry also proposed that this process represents movement toward a fuller expression of one’s deeper potential, what Jung termed ‘individuation’ (Grof & Grof, 1991).

4.9.2 The Central Archetype

Archetypes are seen as dynamic patterns or fields of potential containing both intentionality and total independence. They are innate, instinctual and unlearned and represent the most typical emotional life experiences in symbolic images. Once activated, the archetype manifests in the form of an emotion, an image and a pattern of behaviour (Perry, 1990).

Jung (1959a,b) believed that archetypes gain life and meaning only when you take into account their ‘numinosity’ or their relationship to the living individual, and although he devoted many years to the study of archetypes he concluded that you cannot define an archetype, you can only experience it (see also, Stevens, 1994).

Jung originally described the archetypes as operating within the psyche but later revised his position describing the archetypes as having consciousnesses separate from our own, with the ability to think and act on

their own. Jung also described the archetype as having a 'psychoid' nature, belonging neither to the psyche, nor to material reality, rather existing between consciousness and matter. He also described archetypes as being a collective phenomenon of a transpersonal nature, and thus not created by any one person's history or experience (Grof, 1993).

Jung referred to the Self as the "archetype of archetypes", and saw it as the totality of the individual from which the individual personality emerges (Stevens, 1991). According to Perry (1990), the notion of the Self holds a condensed set of possibilities comprising the potential for systems of values, meanings, beliefs and a design of life all compacted into the mandala image that represents the Self.

Fordham described the central archetype as:

... an organizer of the unconscious: it contributes significantly to the formation of the central ego in which it finds expression especially in conscious experiences of selfhood ... In this formulation, the central archetype, being a part system in the total self, can be introjected, projected, can assimilate other unconscious elements, identify with the ego, be the source of religious experience, the source of the central ego, and function mostly in the unconscious in a compensatory manner until it gets realized, i.e., largely integrated into the ego in individuation ... At the same time, room is left for the personal life of the individual and his relation to the external world as a whole, within the self conceived of as the super ordinate totality (Fordham 1985, pp. 31-33, cited in Urban, 2005).

Jung's concept of the Self is of enormous complexity and several people have tried to capture the essence of Jung's writings. Redfearn, (1983, cited in Gordon, 1985) summarised the different views of the Self as reported in Jung's writings: (1) A primary cosmic totality analogous to the ideas of the Far Eastern religions of the unity of the self with all things and all creatures; (2) The totality of the individual; (3) The subjective experience of a totality; (4) A primary organising force, or agent, external to the conscious self; (5) The unconscious, or the organising centre of the unconscious; and (6) Those parts which emerge from the self.

Gordon (1985) also attempted to classify the manifestations of the Self: (1) The representation of the self by images which function symbolically, e.g., the philosopher's stone, the lotus or the Holy Grail; (2) An oceanic *feeling*, a term to indicate the experience of something infinite, limitless, in a word 'oceanic', that is, the experience of an indissoluble union with the great all; (3) *Goals* established by the self: union, fusion, experience of the limitless and so on, and (4) *Vectors* of the self: drives towards fusion, synthesis, union, love, death as homeostasis, psychological mechanisms such as identification, projection, incorporation, projective identification and so forth.

Archetypes are also seen as dynamic and moving the individual toward a state of actualisation and personal development (Stevens, 1991). The term designated by Jung to describe the psyche's innate process leading to self-determination and self-fulfilment is *Individuation*. Perry (1990) explains how

this process occurs on two levels with the growth of one's personality as well as an elaborate image sequence constituting the 'archetypal individuation process'. The archetypal individuation process involves a play of opposites (e.g., light-dark, order-disorder, life-death) separating, clashing, reconciling and finally uniting to restore a level of harmony and balance. During this process the archetypal centre stands at the midpoint of these activities and when activated stirs up a dynamic play of image and emotion.

4.9.3 The Renewal Process

During the emergence of this archetypal imagery the individual experiences a profound reorganisation of the Self. In his work with 'psychotic' patients, Perry (1990) discovered a recurring pattern, which shared a number of similar themes, which he termed the 'renewal process'. Perry explained how the powerful 'affect-image', bound up in the structure of the old self-images and old world-image is activated and causes disturbance to the psyche. During this time a number of themes become manifest, making up the renewal process. This reorganisation of the Self includes: (1) a focus on the centre; (2) themes centred on death; (3) returning to the beginning; (4) cosmic conflict; (5) the threat of opposite sex; (6) personal apotheosis; (7) sacred marriage; (8) new birth; (9) anticipation of new society; and (10) the quadrated world image.

The renewal process begins with the focus of psychic, cosmic and personal geography on the centre, which represents itself in quadrated circles, quadripartite circles and mandalas. There is a gradual shift of attention from the outer to the inner resulting in an intense activation of the archetypal

imagery. Both the course of the process and the accompanying imagery are directed toward the centre, which represents both that which is being renewed as well as the vessel of transformation.

Next, the renewal process is concerned with the themes of death, including the experience of dying and entering the afterlife, symbolising the dissolution of the familiar self. There may be images of sacrifice, torture or dismemberment, where the person may be tortured or chopped up with the rearrangement of their bones. Another element that arises during this time of the process is that of world destruction, which symbolises the dissolution of the individual's world-image.

Following the theme of death comes the theme of regression, a return to an earlier time, a return to paradise or a return to the womb, which may become manifest with infant-like behaviour. Grof (2000) believes that individuals in this state can go further back than their own personal history, through the history of humanity and back to the creation of the world, to the original state of paradise. He believes this journey offers an opportunity to correct past individual and universal errors in an effort to create a better world.

Next arises a cosmic conflict between good and evil, the higher and lower natures of man, the spirit and the flesh and other such pairs of opposites. Here the individual experiences themselves at the centre of huge events with global or cosmic significance that seem to be critical for the future of the world (Grof, 2000). Perry also suggests that the qualities assigned to these opposite forces may vary with the cultural setting or tradition in which they are experienced.

Another threat of opposites, the threat of the opposite sex, also plays a role in the renewal process. There may be a feeling of being overwhelmed by the opposite sex, alternately this threat of the opposite may also become manifest in terms of a positive identification with the opposite sex.

In the next stage of the process there is a shift from the frightening or nightmarish elements toward inner experiences of a lighter nature. This transformation starts with a perceived elevation or exaltation of the individual to a higher position where they may identify with a hero or heroine, a great world leader, a saint, saviour, messiah or king. This personal apotheosis is often associated with a profound sense of spiritual rebirth, replacing the earlier conflicts with death (Grof, 2000).

While in this exalted state, the person experiences a *hieros gamos*, or “sacred marriage” with a mythical or divine figure, a coming together of the opposites with all the accompanying exhilaration and upsurge of erotic emotion. Grof (2000) believes that this stage symbolises a state of balance between the masculine and feminine aspects of the individual. At this time, one may also experience symbolic representations of the transpersonal centre, one’s deepest and truest nature, in the form of a supernatural source of light, precious stones or other similar images.

In the next stage of the renewal process, the self-image is renewed by a rebirth, or a new birth, often attributed to the fruitful event of the sacred marriage. Grof (2000) believes that this sense of ‘spiritual’ rebirth replaces the individual’s earlier obsession with death.

In what Perry believes to be the most impressive and richest set of images, lays the belief that one has been elected to create a new age, or a

new society on a world scale. This represents the need for the person to live in a harmonious society and offers a glimpse of the new direction in which the psyche is moving.

Finally, the renewal process comes into a state of balance, which is symbolised with the emergence of images of the quadrated world, a four-fold structure of equilibrium and depth, symbolising wholeness. According to Grof (2000) this final stage of the drama can involve four kings or four countries and is often reflected in spontaneous drawings including such motifs as four rivers, four cardinal points or four quadrants.

When the intensity of the visionary experience subsides the individual realises that the entire process was one of inner transformation and by allowing this process to take its natural course Perry was able to recognise the process as restorative and healing.

The Jungian Model regards the high arousal states of the renewal process as activations of the deeper functions of the psyche. These archetypal affect-images are activated when there is urgent need for a new orientation in personality or culture (Perry, 1990). Perry emphasises the significance of these themes, which closely resemble the patterns of the ancient myth and ritual of renewal in the sacral kinships.

Grof and Grof (1991) explain the process and function of the sacral kinships in ancient society:

Quite independently of each other, these cultures celebrated elaborate New Year's festivals, at which time a ritual drama was performed that revolved around the person of the king and had certain standard

themes. After the place of the ritual was established as the centre of the world, dramatic sequences portrayed the death of the king and his return to the beginnings of time and the creation. This was followed by his new birth, sacred marriage, and apotheosis as a messianic hero.

All this happened in the context of a cosmic conflict involving a dramatic clash of opposites-combat between the forces of light and darkness, and confrontation of good and evil. An important part of the royal drama was the reversal of sexual polarities, expressed by the participation of transvestites. The symbolic performance ended with a portrayal of a renewed world and revitalized society. These rituals were considered to be of critical importance for the continued existence and stability of the cosmos and nature, and the prosperity of society. The fact that the experiences that constitute it have such amazing historical parallels has far-reaching significance. It is a critical challenge to the view of these states as indications of mental disease (p.133).

4.9.4 The Renewal Process and Psychopathology

Because of the depth and intensity of the psychological processing taking place during the renewal process, it could resemble a variety of psychotic disorders. Because many people experiencing the process are not aware that the reorganisation of the Self is an inner process, they may believe that the inner psychological processing is taking part in the outside world and express it outwardly.

As an example, during the personal apotheosis stage of the process an individual may identify with an archetypal figure such as the great mother or God. If this identification becomes total and the individual is dominated by the figure they may experience 'inflation of the ego' and the individual would then be recognised as psychotic or delusional (Gordon, 1985).

A further problem can occur when the dynamic process shifts the energy from the higher functions, leaving the ego consciousness and autonomic complexes in a state of fragmentation thus contributing to the 'thought disorder' and 'dulling of affect', so characteristic of this process (Perry, 1990).

However, Perry (1990) believes that if the mental content is closely followed the process can easily be understood as the psyche's effort to transform its entire structure of values, meanings and cultural orientation. The positive healing potential of the renewal process as well as its deep connections with archetypal imagery and myths of antiquity lend support to the argument that these experiences are not the product of psychopathology. From this angle, the pre-psychotic condition of the individual could be considered pathological while the psychotic like episodes occurring during the renewal process can be seen as a process of healing and transformation.

In Perry's (1977) work with many young adults during the acute schizophrenic episode he recognised that it is:

...the attitude of the social milieu itself toward visionary states [that] is...apparently the decisive factor in the formation of the symptoms of psychopathology, and also crucial to the probability that persons

caught in the 'psychotically' altered states of consciousness will be regarded as saints...or will be caged as beings regressed to the level of beasts. ... psychosis then becomes more of a cultural problem than a medical one when seen in the perspective of history (p. 12).

4.9.5 The Renewal Process as Spiritual Emergency

Perry (1990) believes that in order to outgrow a phase of insufficient development and enter into a more enriched phase, the psyche must experience periods of turmoil. If one chooses to remain in their usual state, unshaken by the dynamic activity that may present itself, although they will remain within the bounds of what is considered 'normal', they may also be holding themselves back from achieving their full potential.

Perry (1990) observed that if this inner psychological work is not entered into voluntarily, the psyche is likely to start the process, overwhelm the conscious personality and possibly lead the individual into a state of acute psychosis. If this approach to viewing psychosis is accurate then the development of the personality is in great danger if the process is suppressed with medication. Perry's clinical work has indicated that allowing the inner images (representing emotions and emotional issues) to stir the psyche and reach full completion without the aid of medication, allows the process to give rise to emotional maturity and transformation of the personality.

4.9.6 Summary

Some believe that archetypal images are primordial patterns and form the basic content of religions, mythologies, legends and fairy tales of all ages.

The archetype representing the centre, the central archetype or the Self, is said to express psychic wholeness and totality. During the activation of this archetype it is believed that there is a flooding of dramatic, disturbing and ecstatic imagery into the conscious awareness of the individual. Throughout his work with 'psychotic' individuals, Perry (1990) found a predictable pattern of archetypal imagery that he termed the "renewal process", which if allowed to run its course without the suppressive use of psychiatric medication, could carry the capacity for '*individuation*' or a fuller expression of one's deeper potential.

Viewed in this light, the renewal process is considered to be an innate method for healing restricted development in the psyche as well as the driving force behind reaching full human potential.

As much of the imagery contained in the renewal process is symbolic, a thorough understanding of these primordial motifs would be required in order to gain a level of insight into the process. Without this insight it is easy to dismiss this process as a product of mental illness. However, the potential for positive inner transformation, as well as the rich connections of this process with ancient rituals, makes it unlikely that the renewal process is the product of mental illness.

Therefore, given the positive potential of this process, it would seem the next logical step for professionals working with people experiencing acute 'psychotic' episodes, is to investigate the imagery of the process and determine if some type of pattern emerges.

Continued dismissal of this inner imagery is at the very least a lost opportunity to gain further insight into a process that continues to puzzle

psychiatrists. At most, it can be seen as a failure of the mental health profession to move beyond its self imposed limitations of research, in order to create therapeutic interventions that meet the needs of their clients.

4.10: THE ALIEN ABDUCTION EXPERIENCE

4.10.1 The Alien Abduction Experience

An extensive literature review by Newman and Baumeister (1996) outlined the Alien Abduction Experience (AAE) as starting with the sight of something resembling a UFO, some kind of bright light or the appearance of strange beings. The person is often unable to move and may find themselves somehow being transported into a UFO. Once aboard, the abductee typically find themselves in a brightly lit room filled with unusual equipment. They are often stretched out on a bed, or examining table, while a non-human being performs what the experiencer believes to be some kind of medical examination, often involving painful procedures. Various parts of the body are probed, needles and restraints are sometimes used, cuts are made, blood is often drawn and the abductee usually feels powerless and externally controlled. Genitals often receive special attention, and reports of sexual activities between aliens and abductees have become increasingly common. After the examination, victims' memories are erased, or they are somehow programmed to keep their experiences a secret.

Mack (1992b) describes the confusion that abductees have upon their return. They may be surprised to wake up upside down in their bed, on top of the covers, in another room or outside the house, with or without their clothes.

If the experience occurred whilst driving, they are puzzled to find that they are much closer to their destination than moments earlier, or they may be completely off their intended path. Mack has also found that during some abduction experiences, the individual actually appears to be missing as reported by others.

The analysis of 270 abduction reports by Bullard (1987) found a variety of physical and psychological after-effects including: 11 cases of injuries such as cuts, bruises, and puncture wounds; 22 cases of eye problems; 23 cases of skin burns or irritation; 13 cases of gastrointestinal distress; 14 cases of equilibrium and balance problems; 12 cases of thirst and dehydration and 13 cases of healing from a pre-existing condition. Experiencers also display phobic avoidance of stimuli linked to their experience, sleep difficulties, intrusive affect and images, autonomic hyper-arousal, as well as symptoms related to Post Traumatic Stress Disorder (PTSD), including nightmares, an inability to sleep, being overwhelmed by emotions and occasional flashes of images related to the experience (McLeod, Corbisier, & Mack, 1996).

4.10.2 Models of the Alien Abduction Experience

There are a growing number of explanations for the AAE from various schools of thought, including psychological, neurophysiological, psychopathological, anthropological and mythological. This chapter presents several AAE theories, including fantasy proneness, hypnotisability, sleep paralysis, temporal lobe lability and various forms of trauma.

As the content of AAEs is so far from our everyday experience, it is easy to presume that people experiencing such phenomena may experience

difficulties in distinguishing between fantasy and reality. It has been suggested that difficulties in distinguishing between fantasy and reality may be due to the experiencer's personality characteristics, as well as their efforts to make sense of their extraordinary experience (McLeod et al., 1996). The fantasy prone personality (FPP) is a construct developed by Wilson and Barber (1983) to describe individuals who experience a rich fantasy life and other characteristics such as alleged psychic ability, out-of-body experiences, religious visions, apparitional experiences and hypnotic susceptibility (cited in Bartholomew, Basterfield & Howard, 1991). In a biographical analysis of over 150 contactee and abductee cases from a variety of archival sources, Bartholomew et al. (1991) concluded that the majority of cases indicated histories more consistent with the FPP type than the non-FPP type. However, research by Spanos, Cross, Dickson, and Dubreuil (1993) comparing a group of individuals reporting UFO sightings and alien contact and a group of individuals not reporting such experiences, revealed that UFO experiencers were no more fantasy prone than the control group.

Due to their inability to distinguish easily between actual and imagined experiences, as well as their suggestibility, Newman and Baumeister (1996) suggest that experiencers may be particularly responsive to hypnotic suggestion. It is possible that people having partial memories of some kind of trauma, contact or abduction experience may seek out a hypnotherapist in order to recover the rest of their memories. Appelle, Lynn and Newman (2000), have suggested that the details of the UFO experience, which often emerge during hypnosis sessions intending to recover presumed hidden aspects of a partially remembered experience, may be creating rather than

uncovering UFO abduction memories. According to a literature review by Newman and Baumeister (1996), between 70% and 100% of people experiencing some type of alien phenomenon have constructed their stories under hypnosis. However, there are also many instances when people have recalled their experience without hypnosis, and research by Spanos et al. (1993) did not indicate that individuals reporting UFO or alien phenomena were highly suggestive in comparison to non-experiencers.

A further hypothesis which has been used to explain the abduction phenomenon is sleep paralysis. Spanos et al. (1993) found several similarities between abduction experiences and sleep paralysis. In this sample, the majority of the abduction experiences occurred at night, with nearly 60% of the “intense” reports associated with sleep, and nearly a quarter of the intense experiences involved symptoms similar to sleep paralysis. Awareness during sleep paralysis is likely to be accompanied by hypnagogic and hypnopompic imagery, consisting of anomalous sensory experiences. The “hypnagogic” state, which occurs immediately prior to sleep, refers to sensations such as visual and auditory hallucinations, a terrifying sense of presence, a feeling of pressure on the chest, and the feeling of floating. The “hypnopompic” state refers to the same sensations when they are experienced after sleeping and prior to complete awakening. The visual hallucinations can involve such things as lights, animals, strange figures, and demons, while auditory hallucinations may include heavy footsteps, humming or buzzing noises, and sounds of heavy objects being moved (Holden & French, 2002).

Research by McLeod et al. (1996) has indicated several ways that abduction experiences can be differentiated from traumatic reactions to

simple sleep paralysis. First, a number of abduction experiences occur during the daytime in the waking state. These experiences share clear similarities to those reported at night. Second, individuals from across different cultures, including young children, report similar details, including many which are not reported in the media. Third, experiencers show similar phobic reactions to events and symbolic material associated with the abduction phenomenon that are not linked to sleep alone. Also, insomnia, anxiety and nightmares tend to resolve with the conscious processing of the abduction experience which would be unlikely if the traumatic experience were not directly related to the material. Thus, they conclude that abduction experiencers behave in a way that is indicative of exposure to a traumatic event, outside socially shared reality, and their anxiety is directly related to the details in their narratives.

It has also been argued that the alien abduction phenomenon may be caused by abnormal activity in the temporal lobes. Persinger (2000) has been investigating areas in the brain, as well as electromagnetic patterns within the brain, which are involved with the abduction experience. He believes that most elements of the abduction phenomenon have been evoked with electrical stimulation to the brain. Persinger (1984) suggests that the same areas of the brain are activated in these individuals as in those who suffer from partial complex or temporal lobe epilepsy. However, this does not mean that people who report abduction experiences are suffering from some kind of epilepsy. He explains that people may have different degrees of abnormal temporal lobe activity, with people displaying higher degrees of activity being more prone to “benign limbic experiences” including feelings of presence, depersonalisation and flashback imagery. It has also been found that people

with relatively labile temporal lobes are more prone to fantasy, and more likely to report mystical and out-of-body experiences, visions, and psychic experiences (Persinger & Makarec 1987). However, Spanos et al. (1993) assessed temporal lobe liability using the temporal lobe subscale designed by Persinger and Makarec (1987), and found no difference in temporal lobe liability between individuals reporting UFO phenomena and individuals not reporting such experiences.

Some experiencers also have histories of trauma or sexual abuse. Extensive research by Ring (1993), examining information from over 200 people who reported having both a near-death experience and an AAE, revealed a higher than average level of child sexual abuse. Ring suggests that people with a traumatic background may be more likely to learn to dissociate, so when they experience trauma later in life, they are more readily able to go into a dissociative state. This would make them more susceptible to what Ring calls alternative realities, where he believes the alien encounter takes place. Mack (1994) also speculated about the possibility of the AAE occurring partially in our physical reality and partly in another reality or dimension to which we do not have access by empirical means. In his research he cites several scientists who are confronting the possibility of parallel universes or other dimensions of reality from which information or material may enter our physical world. Swiss psychiatrist C. G. Jung (1964) also believed that this type of phenomenon somehow formed a connection between the psyche or inner world and the physical phenomenon in the outer world.

It has been suggested that UFO and alien phenomena may reflect a basic myth, with each age and culture having its own version. In fact, Mack (1994) investigated Native Americans (the Cherokee, and the Hopi) who recognise similar beings as the "Star People", and In South Africa he undertook in-depth interviews with a medicine man who knows these beings as "Mandingdas". Jung (1964) also suggested that flying discs, as they were called in the 50s, may be a type of contemporary myth, an archetypal symbol of wholeness and unity, originating in the collective unconscious of humanity. Ring (1993) also considered the abduction to be an archetypal journey of initiation with the well-established sequence of separation, ordeal and return. Here, the experiencer is taken away against their will to an unfamiliar place and subjected to a kind of ritual inspection and testing, indicating similarities to the theme of dismemberment in traditional Shamanic initiations.

Similarly, Thompson (1989) explores the UFO encounter experience as a crisis of transformation. He describes the three stages of Arnold Van Gennep's model of rites of passage; separation, marginality and aggregation or consummation, and employs this model to describe how UFO experiencers pass through each of these stages. Grof and Grof (1991) have also indicated that some of the abduction reports include procedures such as scientific examinations and experiments that resemble experiences occurring during Shamanic crisis and various ordeals of initiates in rites of passage conducted by aboriginal cultures.

With respect to each of these theories, a number of important aspects of the AAE have been overlooked, and, to date, no theory can adequately account for all phenomena associated with the AAE. Mack (1992b) believes

that any adequate theory or useful hypothesis of AAE must account for a broad range of puzzling phenomena including at least the extreme narrative consistency in the abductees' stories, the absence of mental illness, the association between AAEs and the independent observations of UFOs, the accompanying bizarre physical effects such as cuts and lesions and the detailed experiences of young children as young as two years old whose exposure to abduction information has been limited.

4.10.3 The Alien Abduction Experience and Psychopathology

Psychopathological disorders that may account for alien abduction experiences are characterised as delusions and include various forms of psychosis and personality disorders as well as dissociative disorders (Holden & French, 2002). As some of the reports sound delusional, such as hallucinations, and even defy our physical laws, the account could suggest some sort of psychosis. But Mack (1992a) believes that psychosis can be ruled out as the majority of abductees in his investigations were clinically quite normal, and, despite the stress related to their abduction experiences, generally function well in society. Abductees are often anxious, or suffer from bodily aches and pains which could indicate some form of neurosis, but psychoneurosis can be ruled out by the fact that abductees do not appear to suffer from the sorts of intense personal conflict that characterise the neuroses (Mack, 1992a). It can be argued that AAEs have an organic impairment of the brain, as recall of their experience is frequently patchy. However, Mack (1992a) believes that their inability to recall details of their experiences is due to the repression of memory that frequently follows trauma.

The AAEs are often traumatic and can contain sexual references, which could point to a history of rape or possible childhood sexual abuse. Also, as the abduction experience often occurs in, or brings about, an altered state of consciousness it is possible to think that we may be dealing with a condition connected with a dissociative response, such as dissociative identity disorder or even Satanic cult abuse. Although Mack (1992a) believed that trauma is certainly an important feature of most abduction experiences, he did not see a single documented case where the source of the trauma proved to be anything other than the abduction itself. It is true that experiencers show some of the symptoms associated with post-traumatic stress, but Mack (1994) argues that these symptoms appear to be the result, not the cause, of what the experiencers have gone through.

If the AAE is not examined carefully it can look like a mass hysteria or delusion, fed perhaps by a great deal of material in the public media. But Mack (1992a) believes that the abduction syndrome does not behave like a collective disorder due to the personal nature of the experience, the isolation between experiencers and information on abductions and they are not manifesting a culturally prevalent or accepted belief.

Although research is limited, current investigations have revealed that abductees do not show more signs of psychopathology than controls (Spanos et al., 1993), they are devoid of a history of mental illness (Bartholomew et al., 1991), are no less intelligent (Spanos et al., 1993), and in fact display average to above-average intelligence (Persinger, 2000) when compared with non-experiencers. Therefore, the hypothesis that abductees are in some way mentally unstable has not been supported by empirical research.

4.10.4 The Alien Abduction Experience as Spiritual Emergency

Although there is a great deal of psychological turmoil associated with the AAE, a number of positive outcomes have also been recorded. Mack's (1992b) investigations have revealed that many abductees become more intuitive, develop philosophical interests, show an increased interest in spirituality as well as developing higher levels of reverence for nature, human life and the environment. The idea that the AAE may be an alternate pathway to some type of psycho-spiritual transformation, similar to the near-death experience, has been suggested by Ring (1993), while Mack (1994) considers the possibility of abduction accounts as being part of a tradition of visionary experience. There have been many reports of lights, which have a supernatural quality unlike anything known on earth and these are strongly reminiscent of visions of light occurring in mystical states as well as other non-ordinary states of consciousness (Grof & Grof, 1989).

Grof and Grof (1989) believe the experiences of encounters with, and abduction by, what appear to be extraterrestrial spacecraft or beings share many important characteristics with mystical experiences and can often precipitate serious emotional and intellectual crisis. Grof and Grof (1991), explain that many of the people experiencing UFO phenomena have been exposed to dimensions of reality ordinarily hidden to human perception and have been profoundly transformed by their experiences. It is unclear whether these dimensions are constructed external realities or states within the unconscious mind. However, as these individuals continue to live in a culture whose worldview they no longer share, there is a greater possibility of

emotional, intellectual and spiritual crisis, much like that precipitated by other forms of spiritual emergency.

4.10.5 Summary

This chapter has presented a number of current theories concerning the Alien Abduction Experience. Neurophysiological theories have included sleep paralysis, hypnagogic and hypnopompic states and temporal lobe epilepsy. Psychological explanations have included fantasy proneness and various forms of trauma. Anthropological explorations have revealed many similarities between the AAE and Shamanic initiations, rites of passage, and important parallels in world mythology which originate in the collective unconscious of humanity. A number of theories put forward to explain the AAE have been highly speculative, including the idea of the experience taking part wholly or partly in another reality or dimension.

However, to date, no theory has been able to explain adequately all aspects of the AAE. For a theory to do so, Mack (1992b) believes that it must be able to account for the simultaneous occurrence among thousands of people, including children, unknown to each other, reporting complex, elaborate, and sometimes overwhelmingly powerful experiences resembling one another in minute detail.

If people reporting observation, contact and abduction by aliens are not mentally ill, as the literature has indicated, then this type of phenomenon seriously challenges the concept of reality currently shared in our culture. The fact that a phenomenon defies conventional explanation or challenges our notions of reality, should not allow us to ignore its existence or prevent us

from exploring its significance (Mack, 1992b). It is precisely this type of inquiry that science needs to evaluate critically in order for us to reach a comprehensive understanding of the implications of the alien abduction experience.

4.11 Conclusion

Spiritual emergency has been divided into ten subtypes. As mentioned earlier, these subtypes do not occur in isolation, and individuals may experience a range of phenomena over a number of subtypes. These groupings do however make the difficult task of researching spiritual emergencies more manageable, as they can be investigated separately.

Each of the ten spiritual emergency subtypes have been introduced, together with a number of medical and non-medical models, which have attempted to account for the various phenomena associated with each subtype. The medical models generally regard the various subtypes of spiritual emergency, or spiritual emergency as a whole, as indicative of some type of mental illness. However, to date, empirical scientific research has not been able to clearly explain all of the phenomena associated with any of the spiritual emergency subtypes.

For each of the spiritual emergency subtypes, a number of non-medical theories have also been presented from various disciplines including psychology, theology, consciousness research, anthropology and sociology. Although each of these fields of enquiry is able to give various interpretations of spiritual emergency, these explanations are often not able to fit in with our

current scientific paradigm and therefore cannot be accepted by the medical institutions.

Some of the spiritual emergency subtypes are fully explainable within a particular socio-cultural paradigm where there is a clear distinction between what has been termed spiritual emergency and mental illness, or deviation from the norm. For example, the symptoms expressed during the awakening of Kundalini are readily understood and integrated within a yogic culture to the extent that the individual is guided through the process back to a state of wellness. The same can be said for the Shamanic initiation crisis, which is generally well understood in cultures where shamanism still plays an integral role in their culture.

However, outside of their socio-cultural climate the experiences associated with the Shamanic crisis and the awakening of Kundalini are little understood. In fact they exhibit many similar, or the same symptoms, which are present in what we have come to call 'psychosis' and are most often diagnosed as such. So, what is considered mental illness in one culture is not necessarily classified as mental illness in another.

Even in the West, the dark night of the soul, the renewal process or the return to the Centre through the central archetype can all be seen as metaphoric journeys through the inner most parts of our being. In this way the often terrifying imagery and outward expressions of the same, which mimic mental illness, can be seen as an attempt of the organism to heal itself. From this viewpoint, these processes can be seen as the healing and not that which needs to be healed. Although difficult, in order to understand these symptoms as part of a metaphoric journey, it is important that we step beyond our

concrete, reductionist way of viewing these experiences and open up to the world of spirit and myth. However, it is also of equal importance that we don't misinterpret mental illness, with a clearly biological cause, as some type of spiritual experience or awakening. To do so may be a sign of psychosis itself.

CHAPTER 5: PSYCHOSIS AND SPIRITUAL EMERGENCY

“The mystic, endowed with native talents . . . and following . . . the instructions of a master, enters the waters and finds he can swim; whereas the schizophrenic, unprepared, unguided, and ungifted, has fallen or has intentionally plunged, and is drowning.”

~Joseph Campbell, *Myths to Live By*

5.1 Brief History of Psychosis and Spiritual/Mystical Experiences

Similarities between mystical experience³⁸ and ‘madness’ have been noted since ancient times. Mystics have long been persecuted for their experiences, which to some may look like mental disorder, but for initiates are signposts that they are on the right path. Even today, the ancient practices of many tribal and indigenous peoples (e.g., spirit possession) would be considered a psychotic disorder to mainstream psychiatrists.

Psychiatry, in general, makes no distinction between mystical experiences and mental illness, and shows no recognition of the contribution made by the great spiritual teachings into the systematic study of consciousness. Consequently the concepts and practices based on centuries of deep psychological exploration and experimentation are dismissed and the fruits of this practice ignored (Grof & Grof, 1989).

James (1902/2007) believed that although the mystical and psychotic experience arises from the same mental level, the flavour of the content is substantially different:

³⁸ Due to the widespread lack of differentiation between ‘spiritual’ and ‘mystical’ in the psychiatric and psychological literature, this chapter will include research that refers to both without differentiating between them.

Religious mysticism is only one half of mysticism. The other half has no accumulated traditions except which the textbooks on insanity supply. Open any one of these, and you will find abundant cases in which 'mystical ideas' are cited as characteristic symptoms of enfeebled or deluded states of mind. In delusional insanity, paranoia as they sometimes call it, we may have a kind of diabolical mysticism, a sort of religious mysticism turned upside down. The same sense of ineffable importance in the smallest events, the same texts and words coming with new meanings, the same voices and visions and leadings and missions, the same controlling by extraneous powers; only this time the emotion is pessimistic: instead of consolations we have desolations; the meanings are dreadful; and the powers are enemies to life. It is evident that from the point of view of their psychological mechanism, the classic mysticism and these lower mysticisms spring from the same mental level... That region contains every kind of matter: 'seraph and snake' abide there side by side (James, 1902/2007, p. 308).

Classical psychiatric literature has also ignored the spiritual dimension of life and has pathologised spiritual experience. The 'oceanic' experience often experienced by the mystics has been reduced to that of infantile helplessness or a regression into primary narcissism (Freud, 1962). Ellis (1980) promoted a similar outlook stating that; "The less religious [patients] are, the more emotionally healthy they will tend to be" (p. 637).

The understanding of mystical and spiritual experiences remains somewhat unchanged in the past 100 years. Grof (1985) believes that if a

member of a typical congregation were to have a profound religious experience, the individual would not be supported within the church but would be sent to a psychiatrist for an assessment. Moody (1975) illustrates this clearly in his research with near-death experiencers (NDErs), when an individual claimed, "I tried to tell my minister, but he told me I had been hallucinating, so I shut up" (Moody, p. 86).

Recently, there has been a growing amount of research investigating religion and its effect on mental health, with many of the findings contradicting the earlier psychiatric point of view. Research examining the relationship between psychopathology and religious commitment revealed that people reporting religious involvement were not associated with higher measures of neuroticism than those with no religious affiliation. The results also indicated that 'religious' people showed higher levels of life satisfaction, indicating that religious affiliation has a positive effect in people's lives (Pfeifer & Waelty, 1995).

Although some level of spiritual or religious practice may be associated with mental health, too much involvement or practice in the wrong circumstances may lead to distress. Assagioli (1989) focussed on the connection between spiritual practice and psychological problems and outlined a number of crisis associated with spiritual awakening. For example, in the aftermath of an intense spiritual experience, one may become 'inflated' or 'grandiose'. This kind of crisis can be triggered when a person becomes dazzled by contact with universal truths that are too great for them to comprehend or they are exposed to energies too great for them to assimilate.

A further type of crisis can occur when the personality is in some way 'inadequate' and unable to assimilate the incoming information. This may occur when there is imbalance in intellect, uncontrolled emotions or imagination either due to a sensitive nervous system or to the overwhelming nature of the inward rush of energy.

Assagioli believed another crisis could occur when the illumination is too great for the mind to comprehend or when egotism or conceit causes the experience to be misinterpreted. In both of these situations, there is confusion between the absolute and relative truth, between the 'Self' and the 'I', and the inflowing spiritual energy may have the adverse effect of feeding the personal ego.

Caplan (1999) outlined a similar danger which can occur when novices naively begin to explore the mystical state without the appropriate guidance or training. This can result in physical and psychological crises as well as adversely affecting one's continued spiritual development. Caplan (1999) and Brett (2002) acknowledge the message from the ancient masters concerning the dangers of 'playing' with intense mystical states. Brett explains that within the Tantric system, these dangers can lead to mental disorder by means of imbalances of spiritual energies relating to emotional and physical symptoms as well as an 'altered experiential structure'.

Breggin (1991) brings attention to the conflicting nature of contemporary society's view of mental illness. Although mental illness is generally held in a negative light, the mentally ill are sometimes recognised as having creative qualities, philosophical worldviews and great sensitivity, which are the same characteristics shown by some of the great mystics. Breggin

suggests that all psychological suffering is a form of spiritual crisis, which can be unravelled in the careful observation of the symbolic, metaphoric language and the preoccupations with the meaning of life, which are both expressed in mentally ill and the mystic.

5.2 Similarities and Differences Between Psychosis and Spiritual/Mystical Experience

There have been a number of studies exploring the similarities and differences between psychosis, madness or mental illness and spiritual or mystical experiences. Although the ancient teachings and great mystics who have delved into the deepest levels of the psyche may have had a thorough understanding of these similarities and differences, the psychological theories still require further development and validation. This section will present a brief overview of psychological literature which attempts to make this distinction.

Daschke (1993) suggests that the mystic's quest for unity is comparable to an individual with a mental disorder who seeks integration of personality, balance of opposites, and unity. Deikman (1971) also sees a similarity between the mystical and psychotic states, believing that they have arisen from a situation where the individual has struggled with a desperate problem, consequently giving up hope. In the case of the mystic, a 'cloud of unknowing' a 'dark night of the soul' or an ecstatic union with God or reality emerges. In contrast, the psychotic's 'world rushes in' but cannot be integrated and a delusion is created to achieve a level of order or control.

Wilber (1980) proposed a number of differences between the psychotic and the mystic. He regards the schizophrenic break as a regression in the service of ego and while this experience is not sought after, and often occurs against the will of the individual, it often leads to personal transformation and a healthier ego. The mystic, exploring the same inner realms as the schizophrenic, is following a carefully mapped out path and learning to master them, rather than becoming overwhelmed by them. Unlike the schizophrenic, the mystic is “not contacting past and infantile experiences, but present and prior depths of reality” (p. 156).

Research using standard psychological measures has attempted to measure and define the similarities and differences between mysticism and psychosis using three groups, comprising of ‘psychotics’, mystical/spiritual ‘contemplatives’ and ‘normals’ (Stifler, et al., 1993). Scores on an Ego-Grasping scale indicated that the normal and contemplative groups could not be differentiated from one another but each scored significantly lower than the psychotic group. As a collective, the contemplative and psychotic groups could be differentiated from the normal group, but could not be differentiated from each other on the Hood Mysticism Scale. In terms of the Narcissistic Personality Inventory, the normals and contemplatives scored significantly lower than the psychotic group, but the normals and contemplatives could not be differentiated from each other.

Further research examining the similarities between the acute mystical experience and schizophrenia, has compared written autobiographical accounts from the two groups. Buckley’s (1981) analysis revealed that the reported experiences occurring at the onset of some psychotic episodes shared a number of characteristics with the acute mystical experience. These

characteristics included: a powerful sense of noesis (knowing); heightening of perception; feelings of communion with the 'divine'; a sense of ecstasy and exultation; hallucinations; the sensation of being enveloped in light; the feeling of being transported beyond the self; a heightened state of awareness; a loss of self-object boundaries; time distortion and perceptual changes.

Buckley's analysis also found some differences between the two states. For example, the disruption of thought and disturbance in language and speech seen in acute psychosis was not reported in the mystical accounts. The flatness of affect present in the psychotic states was not experienced in the mystical state and those in the mystical state tended to experience more visual hallucinations rather than auditory ones. Also, the self-destructive acts and aggressive and sexual outbursts, which sometimes accompany some psychotic states, were not present in the mystical state.

Buckley also revealed that the generally brief and self-limiting nature of the mystical experience differs from the prolonged state of many of the psychoses. However, the condition of schizophreniform disorder was found to differ from the other psychoses due to its somewhat self-limiting nature, and the absence of the usual crystallized delusions, blunted affect and impaired social relations. Due to its self-limiting nature, good prognosis and affect-laden presentation, it has been suggested that schizophreniform psychosis may be a variant of the affective disorders (Pope & Lipinsky 1978; cited in Buckley, 1981). This may suggest that some acute psychotic states may simply share an ecstatic affective change with the classic mystical experience (Buckley, 1981).

A further study by Oxman et al. (1988) used written accounts to compare the subjective experiences of people describing schizophrenia, hallucinogenic drug experiences and mystical experiences, with a control group reporting autobiographical accounts of important personal experiences. The analyses revealed that the words used in each group to describe their experiences significantly differed from one another: The content in the 'schizophrenic' group emphasised more illness and deviance themes; the content in the 'hallucinogenic' group emphasised more altered sensory experience; the content in the 'mystical' group focussed on religious and spiritual issues; while the content of the 'control' group emphasised adaptive and interpersonal themes.

Brett (2002) also examined the differences between the psychotic state and the basic structure of the mystical experience. During the mystical experience the attention is turned inward, away from involvement in worldly matters, with the 'process of perception' becoming the focus of attention. In the psychotic state there is also a shift of attention away from practical, social and sensorimotor activity, but the ego is maintained and, although somewhat distorted and fragmented, with a loss of distinction between the subjective and objective worlds. In the mystical state the arising thoughts and perceptions are passively experienced, leading to non-identification of these mental events, whereas individuals in the psychotic state exhibit less ability to control their attention.

During the mystical experience the discriminating aspect of the mind perceives that the 'self' as 'subject' is separate from mental content, and as an abstraction of pure awareness, illuminates the mental content. In contrast,

the psychotic has less ability to maintain equanimity. This is demonstrated by their confusion, anxiety and emotionality. It has been suggested that these factors impact on the subjective experience of the individual, possibly leading to the kinds of delusions typically found in the psychotic disorders.

In reference to the Tantric Yoga system, Brett (2002) recognises similarities between the bliss of the transcendent vision and the ecstatic period, often experienced at the onset of a psychotic episode. Following the bliss, the yogi can experience anxiety caused by the shift in cognitive organisation which resembles the fear and confusion that sets in following the ecstatic onset of the psychotic experience. Next, both the yogi and the psychotic may experience a sense of rebirth or awakening, which although taken quite literally in the spiritual systems, may be interpreted as delusional for the psychotic.

Podvoll (1979) also recognised a non-ordinary experience at the onset of both psychosis and mystical experiences, where the inner world erupts with states of ecstasy, profound truths, contact with ultimate reality and excruciating insights into the nature of self. He explains that these are the profound personal events, which although initially confusing and impossible to relate to others who have not shared the same experience, make up the life changing qualities of the mystical experience.

Campbell (1972) also identified similarities between the psychotic and the mystic as well as the yogi and the LSD-taker, but "the mystic, endowed with native talents for this sort of thing and following stage by stage the instruction of a master, enters the waters and finds he can swim: whereas the

schizophrenic, unprepared, unguided, and ungifted, has fallen or has intentionally plunged, and is drowning" (p. 209).

Research on the relationship between spiritual experience and psychopathology has suggested that psychotic phenomena can occur in the context of non-pathological and essentially benign, spiritual experiences (Jackson & Fulford, 1992; cited in Jackson & Fulford 1997). In a follow up study, Jackson and Fulford (1997) explored some of the conceptual and practical implications of their earlier findings. They argued that pathological and spiritual psychotic phenomena cannot be distinguished in the traditional ways, including: (1) differentiation via form and content alone; (2) differentiation via their relationship with other symptoms or pathological causes; and (3) reference to the descriptive criteria for mental illness commonly used in the medical model.

Using case studies to back up their earlier findings, Jackson and Fulford (1997) found that the form and content of spiritual experiences were unable to be differentiated using standard diagnostic tools (e.g., Present State Examination) thus calling into question the validity of such measures. Although the spiritual and psychotic phenomena were often qualitatively identical, further inquiry uncovered that distinctions between the phenomena were dependent on the way in which psychotic phenomena themselves are embedded in the values and beliefs of the experiencer. This finding has implications for the diagnosis of psychotic disorders, in particular the need for clinicians to attend to the values and beliefs of their patients to aid in accurate and appropriate diagnosis.

In an effort to differentiate between benign and pathological anomalous experience, Jackson (2001) used case material from individuals reporting experiences that included both. Two distinct groups were formed: (1) An 'undiagnosed group' consisting of individuals who reported experiencing significant period(s) of intense anomalous experience, explained in spiritual/paranormal terms, involving psychotic-like phenomenology with no psychiatric history and displaying positive social adjustment, and (2) a 'diagnosed group' consisting of individuals who have been diagnosed and treated for a psychotic disorder and explained their main anomalous experiences in spiritual/paranormal terms. Jackson examined the case materials differentiating the content, form and process for each group examined. The content revealed several similarities and differences:

- Both groups included religious or paranormal content. The spiritual group contained sub-culturally based, socially accepted content whereas the psychotic experiences group contained idiosyncratic, bizarre and alienating content.
- Both groups expressed a belief in a personal mission or a divine calling with the spiritual group expressing humility and recognition of personal fallibility while the psychotic group expressed themes of grandiosity and a sense of infallibility.
- Both groups had experiences of discarnate entities or a 'sense of presence'. The spiritual group recognised a benign entity whereas the psychotic group experienced a malignant, idiosyncratic entity.

- Both groups had the sense of being guided by external power with the spiritual group retaining volitional control whereas the psychotic group lost their sense of control.
- Intense emotional experience was experienced by both groups with the spiritual group reporting more positive emotions whereas the psychotic group reported more negative emotions.

The form also revealed a number of similarities and differences:

- Auditory and visual hallucinations were experienced. However, the spiritual group reported mostly mood congruent, coherent, friendly visual pseudo hallucinations whereas the psychotic group reported chaotic critical auditory hallucinations.
- The delusions/revelations experienced by the spiritual group were comprehensible beliefs with a presence of insight, in contrast with the psychotics who reported bizarre, incorrigible beliefs with the absence of insight.

It was the processing of the experience where the groups differed most:

- The spiritual group displayed humility, altruism and creativity whereas the psychotic group displayed more self-centeredness and an inability to function.
- The spiritual group believed that their experiences had no major effect on their daily functioning and viewed their experiences as positively constructive and crucial in their personal development and effectiveness. In

contrast, the psychotic group recognised that their experiences had seriously impaired their daily functioning.

- Individuals from both groups believed that their experiences directly addressed their most pressing psychological needs at the time and there were similar phenomenological themes present in both groups.
- The groups differed widely in the short term effects the experiences had on their lives. The spiritual group felt their experiences were helpful and empowering whereas the psychotic group felt isolated and overwhelmed.
- Over the longer term, these differences became blurred with both groups regarding their experience as a means for 'constructive spiritual reorientation'.

Research specifically investigating the similarities and differences between psychosis and spiritual emergencies has revealed that there is a difference between a spiritual emergency and a true psychotic break. Grof and Grof believe that:

People who are in spiritual emergency are still very lucid and have a sense of their own inner processes. Typically, they realise that the changes in their experiential world are due to the changes they are experiencing within and are not the cause of external events. The person afflicted by a true psychosis lacks the insight that her condition has something to do with her own psyche. (Grof & Grof, 1991, p. 44)

Nelson (1994) also believes that “a spiritual emergency differs from ... schizophrenia ... in that the self neither regresses nor retreats in any other way, but actively engages the process even though it temporarily forfeits its ego-based ability to function competently in the social world” (p. 266).

Making the differential diagnosis between psychosis and spiritual emergency can be extremely difficult as there are many shared experiences. In addition, a number of experiences characteristic of spiritual emergency can also appear as symptoms of psychosis. Given this large number of similarities, we need to question whether psychosis and spiritual emergency are actually representations of the same experience viewed through two different models, the medical and the non-medical. In this situation some might argue that spiritual emergency is nothing more than psychosis, whereas others might equally argue that psychosis is nothing more than spiritual emergency.

5.3 Difficulties of Differentiation

There are a number of elements that make the differentiation between psychosis and spiritual emergency difficult: (1) the very constructs we are attempting to differentiate are not clearly defined; (2) the psychiatric diagnostic system has been criticised for being culturally biased; (3) the mainstream psychiatric paradigm is somewhat limited, and (4) there is a lack of understanding of spiritual and mystical concerns among psychiatrists.

First, the very two constructs we are trying to differentiate are not clearly defined both within and across disciplines. Although psychosis is a term used by psychologists and psychiatrists to explain a certain type of

mental illness, psychiatrists are not in agreement on its validity or its diagnostic reliability.³⁹

Compared to psychosis, spiritual emergency is a relatively new concept for psychiatry and psychology, even though human beings have been experiencing the phenomena attributed to the spiritual emergency for thousands of years. Even though many transpersonal psychiatrists and psychologists understand the term spiritual emergency, the concept is still relatively unknown in the mainstream disciplines.

The concept of spiritual emergency has emerged from cross-cultural and cross-disciplinary inquiries and a basic understanding of these two fields is required to adequately understand the concept of spiritual emergency. Once this is grasped, spiritual emergency then needs to be distinguished from psychosis, which is also not a well-understood concept. Since each of these concepts are not well understood or well defined, the differentiation of the two is a difficult task. Differentiation is made even more difficult considering the number of experiential similarities that are shared by both concepts.

A further challenge arises from the way our cultural beliefs shape our understanding of what is 'normal' behaviour and what is pathological. In some cultures, entering into a 'possession' trance is a culturally sanctioned practice, whereas in the West it may be seen as pathological. In Bali, for example, the trance state serves an important adaptive function for indigenous children, and in some parts of Africa, the trance state serves a social and religious function in the raising of Kundalini (Katz, 1973; cited in Sanella, 1997).

³⁹ See chapter 2.

Simons (2001) asks whether these states should be “explained within the conceptual framework of Western psychiatry, or are they best explained anthropologically as manifestations of structural and functional elements operating in the societies in which they are found?” (p. 1). Castillo adds:

The subjective experience of mental illness, its objective presentation (professional definition), its idioms of distress, and its treatment and course of outcome, will all be largely determined by culture-based cognitive categories. Thus each culture will have its own forms of mental illness, although there may be considerable overlap of certain symptoms or symptom clusters across cultures (Castillo, 1994a, p. 5).

Differences in cultural beliefs also have implications for mental health and spirituality. Even within the same culture there are differences in what people consider ‘normal’. For example, ‘speaking in tongues’, although accepted in some charismatic traditions, may not look like ‘normal’ behaviour to one who is not a part of that tradition. However, strange or unusual behaviour is not proof of pathology.

Mental health professionals are known for making culturally based decisions when differentiating between pathological and non-pathological behaviour. A study by Sanderson et al. (1999) examined how mental health professions make judgements about religious authenticity. A number of mental health professionals were given brief accounts of religiously motivated behaviour and were asked to judge how authentic or pathological they were.

Results indicated that “the determining factor in the ratings was not [based on] dimensions of religious experience, but the degree that the experience deviated from conventional religious beliefs and practices. The more unconventional the behaviour, the less religiously authentic and mentally healthy it was deemed to be” (p. 607). These findings support the notion that mental health professions make evaluations based on their own cultural norms.

Another contributing factor in the difficulty of differentiating between psychosis and spiritual emergency is that of the scientific worldview. The beliefs concerning religion and mysticism are determined by the mechanistic and materialistic orientation of western science. Grof (1985) explains that from this point of view, where life and consciousness are seen as accidental products of matter, there can be no genuine recognition of the spiritual.

From this standpoint no distinction can be made between the superficial religious beliefs characteristic of mainstream interpretations of religion, and the depth of genuine spiritual and mystical traditions and other ancient philosophies. The current scientific worldview does not recognise that these traditions are based on centuries of in-depth systematic research into the human mind, and tends to indiscriminately discard any form of spirituality or mysticism.

In this framework many of the phenomena encountered during a spiritual emergency are seen as “gross psychotic distortions of objective reality indicative of a serious pathological process” (p. 334). Grof (2000) believes that these experiences are not artificial products of abnormal processes in the brain, as these experiences belong to the psyche: “Naturally,

to be able to see it this way, we have to transcend the narrow understanding of the psyche offered by mainstream psychiatry and use a vastly expanded conceptual framework” (Grof, 2000, p. 142).

The current materialistic orientation of western science does not value the mystical or spiritual realms. It is not surprising then, that research investigating these beliefs and practices in individuals trained within this worldview, report little or no interest or involvement in mystical or spiritual issues. For example, a survey of training directors from psychology internship centres revealed that 83% of trainers reported that discussions on religious or spiritual issues rarely or never occurred during training. Of these trainers, 100% reported receiving no religious or spiritual training as part of their formal internship. Further, the majority of training directors did not read professional literature on religion or spirituality, and there were no foreseeable plans to address these matters in a new curriculum (Lannert, 1991; cited in Lukoff, et al., 1998).

A further survey of registered APA psychologists revealed that 85% rarely or never discussed religion or spiritual issues during their own training (Shafranske & Maloney, 1990; cited in Lukoff, et al., 1998). This lack of professional interest and understanding in religion or spirituality has serious implications for clients presenting in therapy. Greenberg and Witztum (1991) believe that "differentiating religious beliefs and rituals from delusions and compulsions is difficult for therapists ignorant of the basic tenants of that religion” (p. 563).

The registered APA psychologists further revealed that 60% worked with clients who often expressed personal experiences in religious language. In the

same survey at least one in six of these clients presented issues directly relating to religion or spirituality (Shafranske & Maloney, 1990; cited in Lukoff, 1998, et al.). A further study indicated that 72% of psychologists had addressed religious or spiritual issues with their clients (Lannert, 1991; cited in Lukoff, 1998 et al.).

There has also been a noticeable increase in the number of people in the general public who have been reporting mystical experiences. Gallup polls (1987; cited in Lukoff, 1998) have indicated increases in the percentage of people who report: mystical experiences (from 35% in 1973 to 43% in 1986), contact with the dead (from 27% in 1973 to 42% in 1986), ESP (from 58% in 1973 to 67% in 1986), visions (from 8% in 1973 to 29% in 1986) and other unusual experiences.

Considering that there has been an increase in numbers of people reporting mystical and paranormal experiences, it is disturbing that the registered psychologists and trainers, mentioned previously, have no experience or training in these areas. Given the increase of reported experiences it is likely that they will present more frequently to mental health professionals, which only increases the desperate need for education and awareness in this area. One way to address this need was set in motion by the DSM task force which was set up to up to bring the attention of religious and spiritual needs to the psychiatric community.

"Religious or Spiritual Problem" is a relatively new diagnostic category first appearing in the DSM-IV (Code V62.89). The impetus for this proposal came from concerns raised by the Spiritual Emergence Network with the psychiatric profession's approach to treating intense spiritual crises. It was proposed that a new category would be the most effective way to increase the

competence of the mental health professionals as well as redress the long standing lack of sensitivity to religious and spiritual issues (Lukoff, 1998, et al.).

The proposal of this category argued the following benefits:

- Increased accuracy of diagnostic assessments when religious and spiritual issues are involved.
- Reduced occurrence of iatrogenic harm from misdiagnosis of religious and spiritual problems.
- Improved treatment of such problems by stimulating clinical research.
- Improved treatment of such problems by encouraging training centres to address religious and spiritual issues in their programs.

The definition of this category appearing in the DSM-IV read as follows:

This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values, which may not necessarily be related to an organized church or religious institution. (American Psychiatric Association, 1994, p. 685)

The religious problems in this category consist of: (1) Change in denomination/conversion; (2) Intensification of religious belief or practice; (3)

Loss of faith; (4) Joining or leaving a New Religious Movement or cult, and (5) Other religious problem. The spiritual problems listed in this category include: (1) Loss of faith; (2) Near-death experience; (3) Mystical experience; (4) Kundalini; (5) Shamanistic Initiatory Crisis; (6) Psychic opening; (7) Past lives; (8) Possession; (9) Meditation-related; (10) Separating from a spiritual teacher, and (11) Other spiritual problems. Items on this list of religious and spiritual problems do not indicate pathology, nor are they associated with a co-existing mental disorder, but they may be associated with presenting mental disorders (Lukoff, 1998, et al.).

Lukoff (1985) recognised the possible difficulties for some psychiatrists in recognising or believing in, the positive potential within the psychotic episode. With this in mind, the 'Mystical Experiences with Psychotic Features' (MEPF) model, used to address mystical and psychotic experiences, uses the existing psychiatric diagnostic procedures.

5.4 How can Psychosis and Spiritual Emergency be Differentiated?

The new category of MEPF appearing in the DSM-IV is a positive step toward assisting psychiatrists to determine if the client is in the midst of a psychotic disorder or some type of spiritual problem. This model proposes that there are mystical experiences, psychotic experiences, mystical experiences with psychotic features, and psychotic disorders with mystical features. Further, if the client is experiencing a psychotic disorder, guidelines have been proposed to assist the clinician in differentiation between a psychotic disorder, which offers no positive potential for growth, and the psychotic

disorder, which offers a potential for positive growth. Psychotic disorders with the potential for a positive outcome have been well recognised in the psychiatric literature (Lukoff, 1985). In fact, many clinicians have developed separate categories to distinguish psychotic disorders with this potential, including: problem solving schizophrenics (Boisen, 1962); positive disintegration (Dabrowski, 1964); creative illness (Eellenberger, 1970); spiritual emergencies (Grof & Grof, 1989); metanoic voyages (Laing, 1971) and visionary states (Perry, 1977; cited in Lukoff, 2007).

Although a difference between a psychotic disorder offering the opportunity for positive growth and a psychotic disorder not offering the same potential has been recognised, there are still other problems involved in differentiating the two. For example, Bragdon (1988) has outlined a number of difficulties in making a differential diagnosis between a spiritual emergency and psychopathology. The unusual experiences, behaviours and perceptions (e.g., visual, auditory, olfactory or kinaesthetic) characteristic of spiritual emergencies can also appear as the symptoms of mental disorders (e.g., delusions, loosening of associations, markedly illogical thinking, or grossly disorganized behaviour).

Despite the difficulty in differentiation, it is of great importance to do so, and several models have been proposed. Grof and Grof (1986) produced the original criteria for defining the characteristics of an individual experiencing a spiritual emergency. These include:

- Episodes of unusual experiences that involve changes in consciousness and in perceptual, emotional, cognitive and

psychosomatic functioning, in which there is a significant transpersonal emphasis in the process, such as dramatic death and rebirth sequences, mythological and archetypal phenomena, past incarnation memories, out-of-body experiences, incidence of synchronicities or extra-sensory perception, intense energetic states (Kundalini awakening), states of mystical union, identification with cosmic consciousness, etc.

- The ability to see the condition as an inner psychological process and approach it in an internalised way; the capacity to form an adequate working relationship and maintain the spirit of cooperation. These criteria exclude people with severe paranoid states, persecutory delusions, and hallucinations and those who consistently use the mechanisms of projection, exteriorisation, and acting out.
- Absence of an organic brain disorder underlying abnormal functioning (e.g., infection or tumour).
- Absence of a physical disease of another organ or system which is responsible for the mental disorder.
- Reasonably good general somatic and cardiovascular condition, allowing the client to endure safely, physical and emotional stress frequently associated with the experiential work and with the uncovering strategy.
- Absence of a long history of conventional psychiatric treatment and hospitalisations which generally tend to make the application of new [therapeutic] approaches much more difficult and in many cases impossible.

Nelson (1994) also proposes a number of characteristics that can be used to distinguish the spiritual emergency from the psychotic state. These include “(1) onset precipitated by a stressful life event or involvement in spiritual practice; (2) ecstatic mood, although there may be attendant anxiety; (3) only mildly disorganized thinking; (4) hallucinations of the "higher order"; (5) intact reality testing; (6) good social functioning prior to the onset of the [altered state of consciousness] ASC; (7) insight that something within has changed; (8) absence of paranoia, although there may be appropriate fear; (9) positive and exploratory attitude toward the experience as relevant to one's life; (10) limited duration of the ASC; and (11) enhanced social and personal functioning when the episode is over” (p. 266).

To date, Grof and Grof (1986, 1989) and Lukoff (1985) have proposed the most comprehensive guidelines to differentiate a ‘standard’ psychotic episode from a psychotic episode offering the potential of positive growth. Lukoff (1985) provides an exhaustive diagnostic criterion for making the differential diagnosis between the mystical and psychotic experience. Lukoff lists three main criteria that need to be taken into consideration when making a diagnosis of MEPF: (1) an overlap with mystical experience; (2) the likelihood of a positive outcome, and (3) the individual must be low risk.

Overlap with Mystical Features: Following a search of the mystical literature, Lukoff proposed that the following five characteristics are consistent features of the mystical experience. They also form the criteria that define the overlap between the mystical and psychotic experience: (1) Ecstatic mood; (2) Sense of newly-gained knowledge; (3) Perceptual alterations; (4) Delusions

(with themes related to mythology), and (5) No conceptual disorganisation (pp. 167-169).

The Likelihood of a Positive Outcome: Lukoff (1985) also suggested that two of the following criteria must be present in order to predict a positive outcome for the psychotic episode:

- Good pre-episode functioning, as evidenced by no previous history of psychotic episodes, maintenance of social network of friends, intimate relationships with members of the opposite sex (or same sex if homosexual) and some success in a vocation or school.
- Acute onset of symptoms during a period of three months or less.
- Stressful precipitants to the psychotic episode, such as major life changes (e.g., death in the family, divorce, loss of job, financial problems, beginning of new academic program or job) or major life passages with resulting identity crisis (i.e., transition to adulthood).
- Positive exploratory attitude toward the experience as meaningful, revelatory and “growthful”.

If at least two of these criteria are met, there would be a high likelihood for a positive outcome and suitable treatment recognising the positive potential should be offered to the individual.

Low Risk: Some psychotic disorders can be high risk for suicidal or homicidal behaviour. People should only be deemed at high risk if the danger seems immediate and severe. Bizarre behaviour posing no risk to self or others does not warrant exclusion.

If the spiritual emergency, mystical experience with psychotic features, or psychotic experience with mystical features are correctly diagnosed, the opportunity for a full recovery is likely. With the correct support and treatment the experience may also provide an opportunity for personal growth.

It is impossible to provide a differential diagnosis between spiritual emergency and psychosis in the same way that medicine differentiates between different forms of organic brain disorder, because functional psychosis is defined psychologically (Grof, 2000). In recognition of this difficulty, Grof (1991) suggested that it may be more beneficial to determine which “characteristics of a non-ordinary state of consciousness suggests that one might expect better results with alternative strategies than with treatments based on the medical model” (p. 34). This would also be beneficial in determining when an alternative approach (e.g., transpersonal therapy) may not be appropriate and the episode would be best treated using the standard psychiatric practice of suppressing the symptoms (Grof, 2000). Grof outlined several prerequisites including: (1) a good medical examination eliminating organic conditions that require biological treatment; (2) the presence of biographical, perinatal, and transpersonal experiences;⁴⁰ (3) a recognition that the episode is an inner process; (4) an open exploratory attitude toward experiential work; (5) the capacity to form a trusting working relationship, and (6) the person is able to describe their experience in a coherent and articulate way, however extraordinary and the content might be.

Although guidelines to differentiate between spiritual emergency and psychosis have been offered, there is still the possibility of misdiagnosis.

⁴⁰ Grof (2000) uses these terms ‘biographical’, ‘perinatal’, and ‘transpersonal’ to describe the extended cartography of the psyche.

There are two major diagnostic errors concerning spiritual emergency that can be made. First is the failure to recognise the spiritual emergency and thus reduce it to mental illness. In this case the person will be subjected to unnecessary psychiatric treatment, which may magnify the symptoms and reduce the opportunity for healing. Second is the failure to recognise the psychopathology within the experience and make a diagnosis of spiritual emergency (Grof & Grof, 1989). In this situation the person may not get the medical attention they require and may fall victim to further distress (Grof & Grof, 1991; Lukoff, 1985). The task of this differentiation becomes considerably more difficult when Lukoff's MEPF model is taken into account. In the situation where there is a crossover between mystical experience and psychosis, both the psychosis and the mystical features need to be acknowledged and treated accordingly (Lukoff, 1985).

5.5 The Importance of Differentiation

There are a number of reasons why the differentiation between psychosis and spiritual emergency are of utmost importance. As mentioned earlier, many health professionals have recognised the positive healing potential in some psychotic illnesses. The psychiatrist needs to be aware of these potentials and search out indicators during the initial assessment so that the best possible treatment can be delivered. Lukoff (1985) has provided a solid framework, which assists the clinician in accurately diagnosing episodes of psychosis with growth potential. He emphasises that the correct diagnosis would improve prognosis by providing appropriate treatment consistent with the individuals need to express and integrate their experiences.

Accurate diagnosis would also reduce the insensitive use of pathological labels, and the need for hospitalisation and excessive amounts of medication, which can interfere with the positive potential of the process (Grof & Grof, 1991; Lukoff, 1985).

A strong argument against the use of medication lies in the belief that the psychotic episode is not in itself the illness that needs to be healed, but rather it *is* in itself the healing process. If understood in this light, the use of medication is highly inappropriate as it not only holds the possibility of serious short term or permanent damage, but it will also hinder the self-healing process. Grof and Grof (1991) believe that “the ensuing long-term dependence on [medication] (with their well-known side effects), loss of vitality, and compromised way of life presents a sad contrast to those rare situations where a person’s transformative crisis is supported, validated and allowed to reach completion” (p. 43).

Through his work with psychotic individuals, Perry (1990) also recognised that medication interfered with the innate healing process. He discovered that if the imagery from the depths of the psyche has an opportunity to emerge, then the healing process could take place at its own volition and move through the process of reorganising the Self. He also stressed the importance of a close, supportive working relationship with another individual to encourage the process to reach completion.

This supportive, non-interfering stance has also been recognised in some indigenous cultures. Based on his understanding of the Shamanic crisis, and its similarities to the spiritual emergency, Walsh (2007) outlined a number of factors, which he believes to be essential for a positive outcome. These

include: (1) the need for a trusting, supportive relationship where the individual feels cared for and safe; (2) there needs to be a positive reinterpretation of the experience and an expectation that the process will prove valuable, and (3) the sharing of the experience in a caring and supportive atmosphere.

Jackson (2001) raised a further point in relation to how one's experience can be affected by the way others relate or react to the individual's experience. He believed that "whether a specific experience is viewed by important others as an authentic spiritual experience, a meaningless anomaly or a sign of madness is likely to have powerful repercussions for the individual's response to it" (p. 170). Greyson and Harris (1987) also recognised the issue of attitude in relation to the NDE where the doctor's response to the NDE could determine whether it was seen as a positive experience facilitating growth or a negative experience showing signs of mental instability.

5.6 Conclusion

There has been a long shared history of psychosis and mysticism, and although the mystics were often seen as mentally ill, the current literature does not support these claims.

There are a number of difficulties hindering the psychiatric profession in recognising the positive potential in the mystical or spiritual content in the psychotic experience. This may be due to unclear definition of the concepts, the limiting scientific paradigm, the lack of understanding of mystical and spiritual matters, and the possibility of cultural bias. Recognising these

difficulties, Lukoff, Lu and Turner (1998) proposed a new diagnostic category for the DSM in order to make it more culturally appropriate and to aid in the identification of spiritual or religious problems.

Grof and Lukoff have also proposed guidelines to assist mental health professionals in recognising the positive potential in the psychotic experience. This differentiation between 'normal' psychotic episodes and psychotic episodes with growth potential or spiritual emergencies is of great importance to the individual experiencing them.

If a patient presents with a spiritual emergency or psychotic disorder with positive potential, it is the role of the mental health practitioner to be aware of the symptoms, make a correct 'diagnosis' and offer the appropriate support or care plan. In order for the practitioner to be able to make that diagnosis, they must be well versed and preferably experienced in the qualitative dimensions of the entire spectrum of altered states of consciousness.

Given the increasing interest and experience in the mystical and spiritual traditions, an appropriate and user-friendly system of classification as well as comprehensive education in a wide range of spiritual and mystical traditions, are of utmost importance for all mental health practitioners. Given the vast amount of information supporting the notion of a psychotic disorder with positive potential, anything less could be seen as professional negligence.

CHAPTER 6: METHOD

6.1 Introduction

The first objectives of this thesis, to examine the conventional model of psychosis, outline its shortcomings, and to determine the validity of the concept of spiritual emergency, have been completed. The literature review and critical analysis of psychosis have revealed long-standing inconsistencies within the medical profession concerning the validity of psychosis as a medical condition as well as the reliability of the diagnosis.

Gaining a fundamental understanding of the concept of spiritual emergency is also fraught with difficulty. Spiritual emergency is a relatively new field of enquiry within the professions of western psychiatry and psychology, hence there is a lack of scientifically peer-reviewed papers published on the subject. Much of the published work on spiritual emergency has a 'new age' tint and lacks empirical research and critical evaluation. Another difficulty lies in grasping the vastness of phenomena occurring during a spiritual emergency and the similarity of these experiences with those commonly diagnosed as psychotic.

The literature has indicated a crucial need for the differentiation between psychotic mental illness and spiritual emergency. A correct diagnosis followed by the most appropriate treatment is of utmost importance to facilitate the best possible outcome for the individual.

It is therefore imperative for professionals working in the mental health system to be able to recognise the symptoms of spiritual emergency before the individual is subjected to treatment in the psychiatric system for psychotic illness. With this necessity in mind, a major aim of the present research was

to develop a psychometric measure that differentiates between psychosis and spiritual emergency. This chapter outlines the procedure for the research and the construction of the measure.

6.2 Participants

A total of 109 participants consisting of 64 females and 45 males completed the experimental questionnaire. They ranged in age from 11 to 86 (age missing for 3 persons), with $M = 45$ years ($SD = 15$). Although the researcher specified that all participants must be over 18, one questionnaire was received from a 12 year old boy who did the questionnaire with his mother. As his answers did not differ significantly from the other participants it was decided to include his questionnaire in the study. Most participants were members of the local community and they were all volunteers who showed an interest in the area of inquiry.

6.3 Materials

The Spiritual Emergency Scale⁴¹ (SES) was constructed for this research as a result of extensive study of the literature on psychosis and spiritual emergency. It consists of two parts. Section 1 consists of demographic variables; self reported measures of religious and spiritual beliefs and practice, namely, (1) self-reported religiosity, (2) self-reported spirituality, (3) method of spiritual practice (meditation, awareness, prayer, yoga, various and other), (4) how frequently they engage in this practice, and (5) how many years the participant had been on their spiritual path, as well as

⁴¹ See Appendix 2.

history of psychosis, medication usage, and attendance at a mental health professional.

Section 2 consists of 108 questions to which a “yes” or “no” answer is required. The questions derived from 84 randomly positioned items from the 10 spiritual emergency subscales, as well as a 15-item Experience of Psychotic Symptoms Scale (EPSS) composed for this study, and a 9-item Lie Scale (Eysenck & Eysenck, 1964).⁴²

The ten spiritual emergency subscales were intended to measure (1) Dark Night of the Soul (7 items), (2) the Awakening of Kundalini (11 items), (3) Shamanic Crisis (10 items), (4) Peak Experiences (7 items), (5) Psychic Opening (13 items), (6) “Past-Life” Experience (5 items), (7) Near-Death Experience (8 items), (8) “Possession” States (8 items), (9) the Activation of the Central Archetype (9 items), and (10) Experiences of Close Encounters with UFOs (6 items).

6.3.1 The Spiritual Emergency Sub-Scales

The Spiritual Emergency subscales were compiled via a literature search using David Lukoff’s criteria for types of spiritual problems (Lukoff, 2007), Stan and Christina Grof’s Spiritual Emergency subscales (Grof & Grof, 1991) and the subscales used by the Spiritual Emergency Network (SEN⁴³).

David Lukoff lists the following typology for spiritual problems on his web based resource centre: Mystical experiences, Near-death experiences, Meditation and spiritual practices, Psychic experiences, Visionary experiences,

⁴² A list of the questions making up each of the subscales has been attached as Appendix 3.

⁴³ www.nor.com.au/community/spiritualemergence

Shamanic experiences, Alien encounter experiences and Possession experiences.

The Spiritual Emergency Network lists the following as types of spiritual emergency on their Australian Website: Ego-death/ dark night of the soul, The awakening of Kundalini, Shamanic crisis, Episodes of unitive consciousness, Crisis of psychic opening, Past-life experiences, Near-death experiences, Possession states and Psychological renewal through the central archetype

Grof and Grof (1991) identified the following types of spiritual emergency; Episodes of unitive consciousness (peak experiences), The awakening of Kundalini, Near-death experiences, Emergence of “past-life memories”, Psychological renewal through return to the centre, The Shamanic crisis, Awakening of extrasensory perception (psychic opening), Communication with spirit guides and “channelling”, Experiences of close encounters with UFO’s and “possession” states.

The current scales were constructed in order to integrate the above into an overall measure of “Spiritual Emergency” incorporating as much of the groundwork research as possible

6.3.2 The Experiences of Psychotic Symptoms Sub-Scale

The EPSS was constructed for this thesis using the symptoms listed in the DSM-IV “Schizophrenia and other Psychotic Disorders” chapter, currently used as the diagnostic criteria for psychosis.

6.3.3 The Social Desirability Sub-Scale

The Lie scale (Eysenck & Eysenck, 1964) was used as a measure of Social Desirability, a trait thought to have been present in some people taking part in this type of research.

6.4 Procedure

Ethics approval was gained from The University of Adelaide Human Research Ethics Committee. In order to recruit participants, an article outlining the research was published in a local newspaper and the majority of participants contacted the researcher directly via the article. The remaining participants were recruited by word of mouth through the researcher or through other participants and showed an interest in the research.

Participants were informed that the study was an investigation into a variety of extraordinary physical, mental and spiritual experiences. An application package consisting of an information sheet⁴⁴, a consent form and a copy of the “SES” was sent to participants via mail or over the Internet. Participants were asked to complete the self-administered test and return it within two weeks, with the majority being returned within one month. Two elderly people asked to have the questionnaire administered in person. In these instances, the researcher read the questions from the questionnaire and recorded the answers. No further interpretation of the questions was given by the researcher.

A second round of questionnaires was sent to approximately half of the initial participants and completed by 41 of the initial participants, making up

⁴⁴ See Appendix 1

38% of the total. These were returned between eight and twelve months after the first questionnaire was completed in order to obtain estimates of test-retest reliability.

6.5 Design and Analyses

The design and methods used in this study were deemed appropriate for constructing multiple questionnaire scales. The questions for each of the scales were formulated according to the symptoms represented in the literature.

The descriptive statistics and frequency distributions for the psychotic symptoms scale and each of the spiritual emergency sub-scales are presented in Chapter 7 in order to show the level of internal reliability of these scales. Test-retest coefficients were also computed.

Next, as suggested in the introduction, it was considered useful to determine a cutoff score at the high end of each spiritual emergency sub-scale, above which the person may be more confidently said to have experienced that type of spiritual emergency. It was also decided that the mean EPSS score *above* the cutoff and *below* the cutoff would be examined. If the scale proved adequate, it was then to be added to the spiritual emergency sub-scales and subjected to factor analysis, in order to examine whether the scales were independent of each other.

Next the relationship between the SE subscales, and five extra variables relating to levels of religiosity and spirituality (viz., self-reported religiosity, self-reported spirituality, method of spiritual practice, frequency of spiritual practice, and years on the spiritual path) would be examined in order

to determine if these had an effect on reported levels of SE or psychosis. The validity of the EPSS were then to be tested, by examining the scores in relation to three variables, or psychotic indicators, measuring medication and the presence of psychotic episodes. Due to the length of the questionnaire, a principal components analysis was utilized to construct a shorter spiritual emergency scale and the correlation between the EPSS and the new Spiritual Emergency Scale was also examined.

CHAPTER 7: RESULTS

7.1 The Experience of Psychotic Symptoms Scale: Distribution and Statistics

Descriptive statistics for the EPSS and the ten spiritual emergency scales are found in Table 7.1 and the frequency distribution for the EPSS is shown in Figure 7.1.

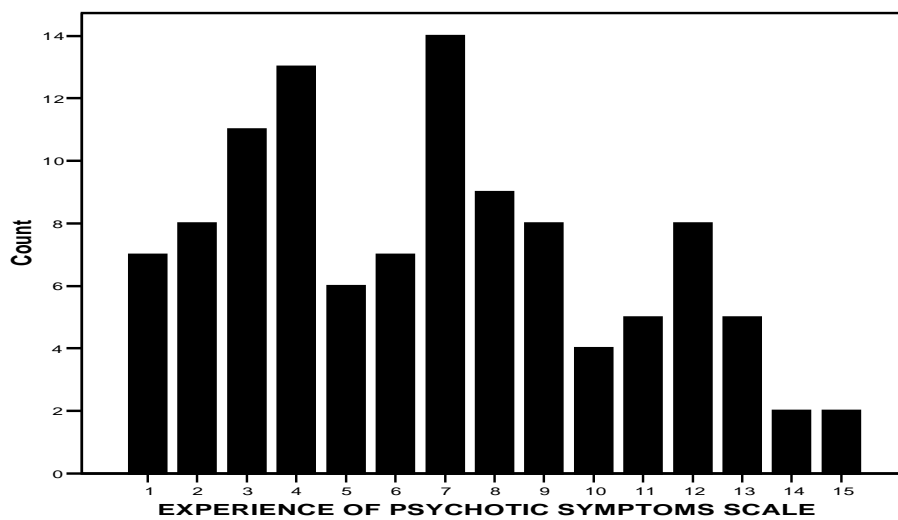


Figure 7.1. Frequency distribution for the Experience of Psychotic Symptoms Scale

Note that for the Experience of Psychotic Symptoms Scale (EPSS) the scores are distributed right across the theoretical range, that the mean and median are approximately halfway between minimum and maximum, and Cronbach's alpha and the test-retest coefficients were both satisfactory.

Table 7.1 also shows that this state of affairs tends to be true of seven of the ten spiritual emergency scales, namely, Dark Night, Kundalini, Shamanic Crisis, Psychic Opening, Past-Life Experience, Near-Death Experience, and Central Archetype, though the distributions were in some cases not normal.

Table 7.1

Descriptive Statistics for the Experience of Psychotic Symptoms Scale and the Ten Spiritual Emergency Scales (N = 109)

Scale	# of Items	Theoretical range	Actual range	M	SD	Mdn	Cronbach's alpha	Re-test reliability	Skewness	Kurtosis
Experience of Psychotic Symptoms	15	0-15	1-15	6.75	3.77	7.00	.82	.84	normal	normal
Dark Night	7	0-7	0-7	3.78	1.89	4.00	.67	.75	normal	normal
Kundalini	11	0-11	0-11	4.36	2.87	4.00	.77	.88	normal	normal
Shamanic crisis	10	0-10	0-10	4.72	2.70	5.00	.78	.85	normal	flat
Peak experience	7	0-7	0-7	5.14	2.11	6.00	.84	.67	negative	normal
Psychic opening	13	0-13	1-13	8.09	3.37	9.00	.83	.88	negative	normal
Past-Life	5	0-5	0-5	2.24	1.73	2.00	.78	.88	normal	flat
Near-death experience	8	0-8	0-8	3.94	1.98	4.00	.71	.83	normal	normal
"Possession" states	8	0-8	0-8	1.75	2.00	1.00	.76	.85	positive	normal
Central Archetype	9	0-9	0-9	3.50	2.50	3.00	.72	.85	normal	normal
Encounters with UFOs	6	0-6	0-5	0.91	1.10	1.00	.53	.86	positive	peaked

In contrast, Peak Experience tended to give very high scores, while “Possession” States and Encounters with UFOs tended to give very low scores.

7.2: The Individual SE Subscales: Distributions and Statistics

Note that in the case of all ten spiritual emergency subscales the reader should see Table 7.1 for descriptive statistics, and Table 7.2 for a comparison of the EPSS scores of individuals scoring *at or above the cutoff* of the spiritual emergency scale and the EPSS scores of individuals scoring *below* the cutoff. Note that in every case, persons scoring at or above the cutoff yielded significantly higher EPSS scores than those scoring below the cutoff (i.e., reported more psychosis).

I. The Dark Night Subscale

Figure 7.2 gives the frequency distribution of the scores for this Subscale. The distribution of scores is normal.

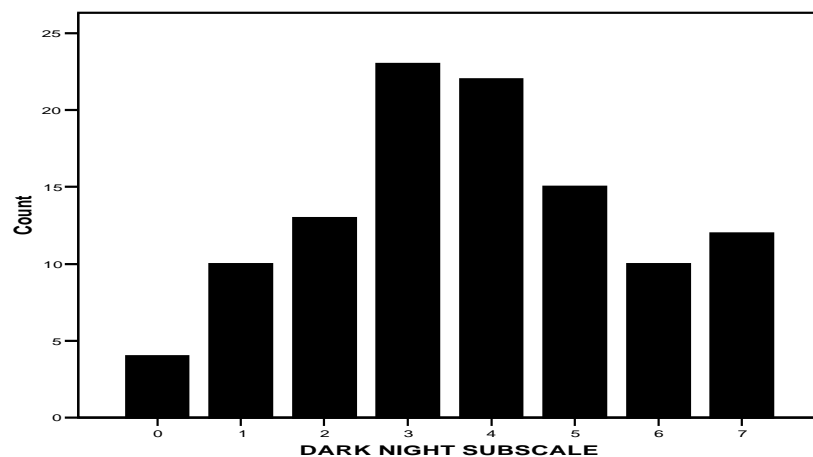


Figure 7.2. Frequency distribution for the Dark Night Subscale.

Table 7.2

Comparison of Mean Score for Experience of Psychotic Symptoms Scale, for Persons At or Above Cutoff and for Persons Below Cutoff, for 10 Spiritual Emergency Scales

Scale	Cutoff	N		M_{above}	SD_{above}	M_{below}	SD_{below}	$F(1, 107)$	p	Partial η^2
		above	below							
Dark Night	6	22	87	10.36	3.06	5.84	3.37	32.80	< .001	.24
Kundalini	7	26	83	10.19	2.83	5.67	3.36	38.32	< .001	.26
Shamanic crisis	7	32	77	9.88	3.40	5.45	3.11	43.34	< .001	.29
Peak experience	7	42	67	8.38	3.19	5.73	3.76	14.35	< .001	.12
Psychic opening	11	32	77	10.00	3.25	5.40	3.09	48.48	< .001	.31
Past-Life	4	28	81	9.18	3.55	5.91	3.48	18.11	< .001	.15
Near-death experience	6	21	88	9.57	3.22	6.08	3.59	16.69	< .001	.14
"Possession" states	4	20	89	11.60	2.48	5.66	3.09	64.38	< .001	.38
Central Archetype	6	27	82	10.00	3.22	5.68	3.03	35.11	< .001	.25
Encounters with UFOs	2	21	88	9.24	3.58	6.16	3.58	12.54	.001	.11

II. The Kundalini Subscale

Figure 7.3 gives the frequency distribution of the scores for this Subscale.

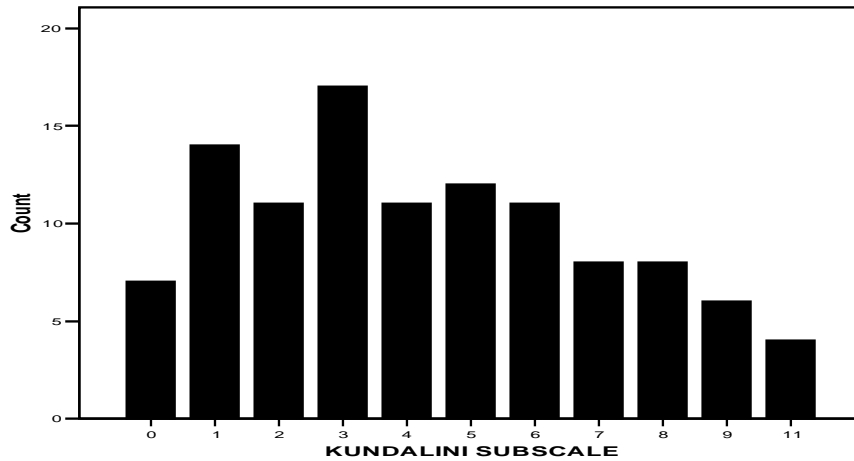


Figure 7.3. Frequency distribution for the Kundalini Subscale.

The distribution of scores is normal.

III. The Shamanic Crisis Subscale

Figure 7.4 gives the frequency distribution of the scores for this Subscale. While skewness is normal, the distribution is significantly flat.

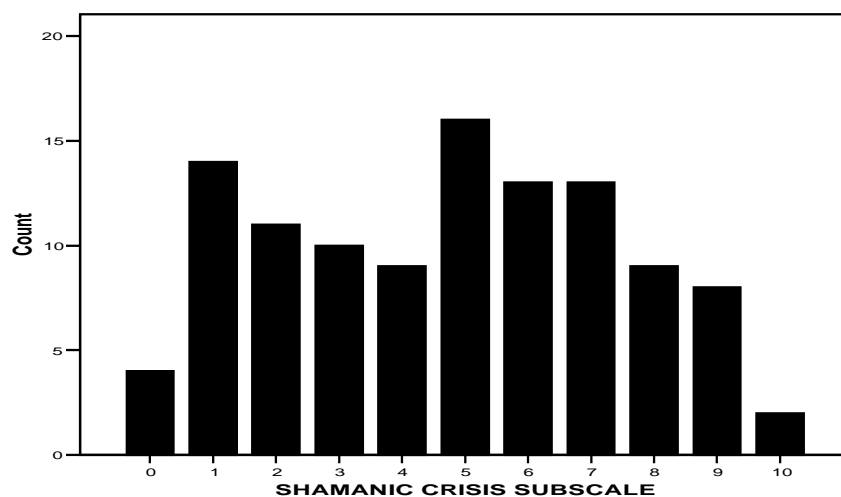


Figure 7.4. Frequency distribution for the Shamanic Crisis Subscale.

IV. The Peak Experience Subscale

Figure 7.5 gives the frequency distribution of the scores for this Subscale.

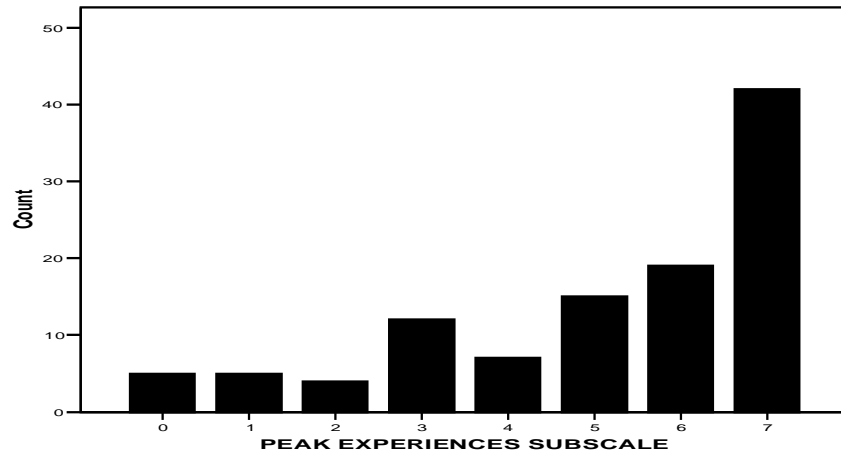


Figure 7.5. Frequency distribution for the Peak Experience Subscale.

While kurtosis is normal, the distribution is significantly negatively skewed.

V. The Psychic Opening Subscale

Figure 7.6 gives the frequency distribution of the scores for this Subscale.

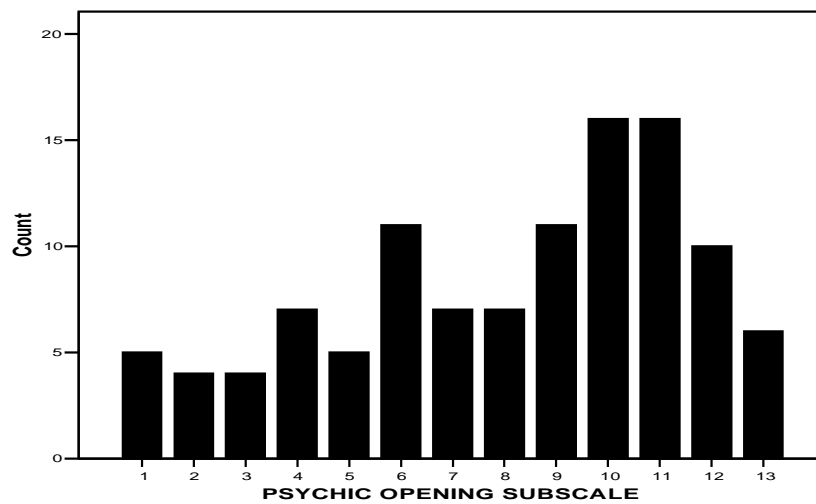


Figure 7.6. Frequency distribution for the Psychic Opening Subscale.

While kurtosis is normal, the distribution is significantly negatively skewed.

VI. The “Past Life” Subscale

Figure 7.7 gives the frequency distribution of the scores for this Subscale. While skewness is normal, the distribution is significantly flat.

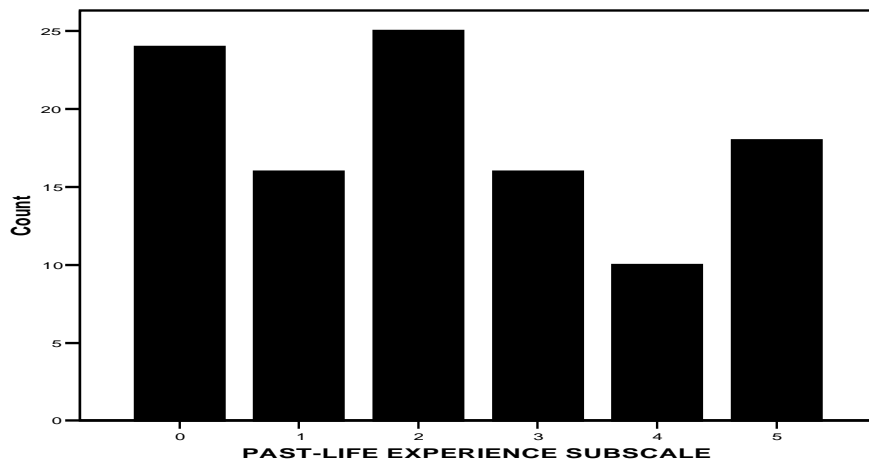


Figure 7.7. Frequency distribution for the Past-Life Experience Subscale.

VII. The Near-Death Experience Subscale

Figure 7.8 gives the frequency distribution of the scores for this Subscale. The scores on this scale are normally distributed.



Figure 7.8. Frequency distribution for the Near-Death Experience Subscale.

VIII. The "Possession" States Subscale

Figure 7.9 gives the frequency distribution of the scores for this Subscale. While kurtosis is normal, scores are positively skewed.

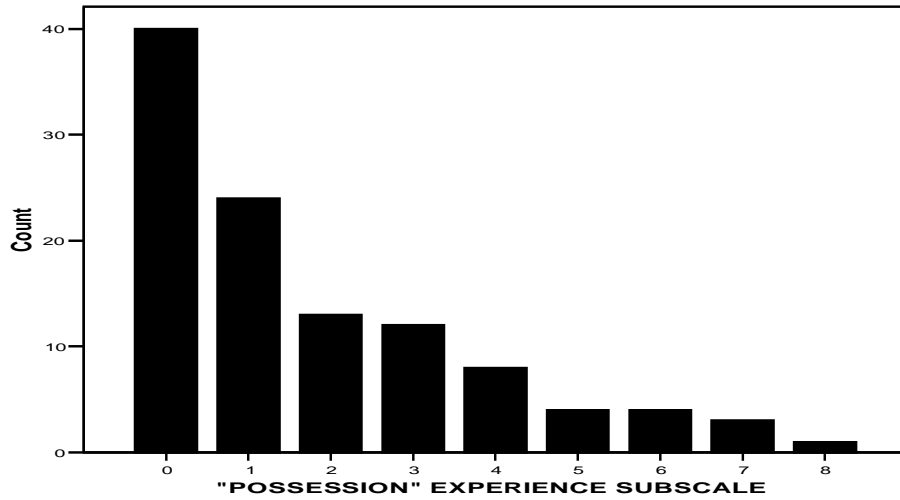


Figure 7.9. Frequency distribution for the "Possession" States Subscale.

IX. The Central Archetype Subscale

Figure 7.10 gives the frequency distribution of the scores for this Subscale. The scores on this scale are normally distributed.

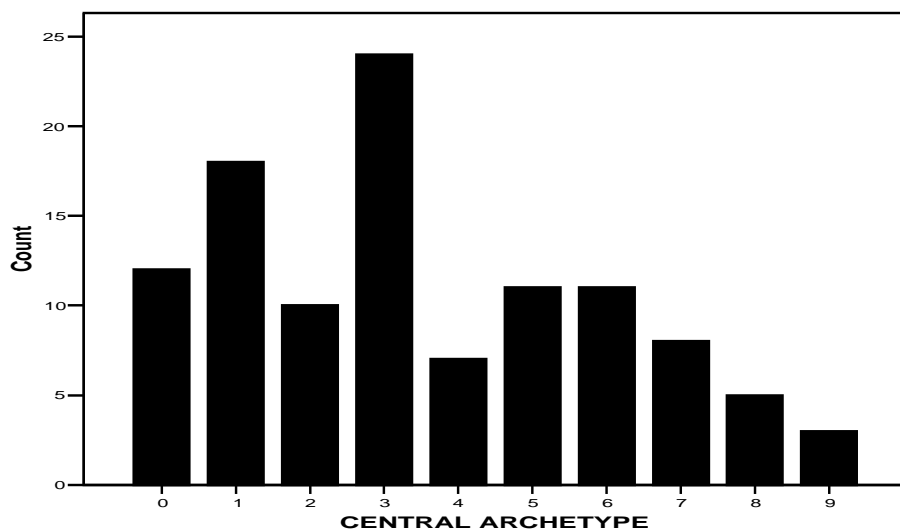


Figure 7.10. Frequency distribution for the Central Archetype Subscale.

X. The Close Encounters with UFOs Subscale

Figure 7.11 gives the frequency distribution of the scores for this Subscale. The scores on this scale deviate markedly from normality, in that they are positively skewed (i.e., low scores are more common) and they tend to be peaked.

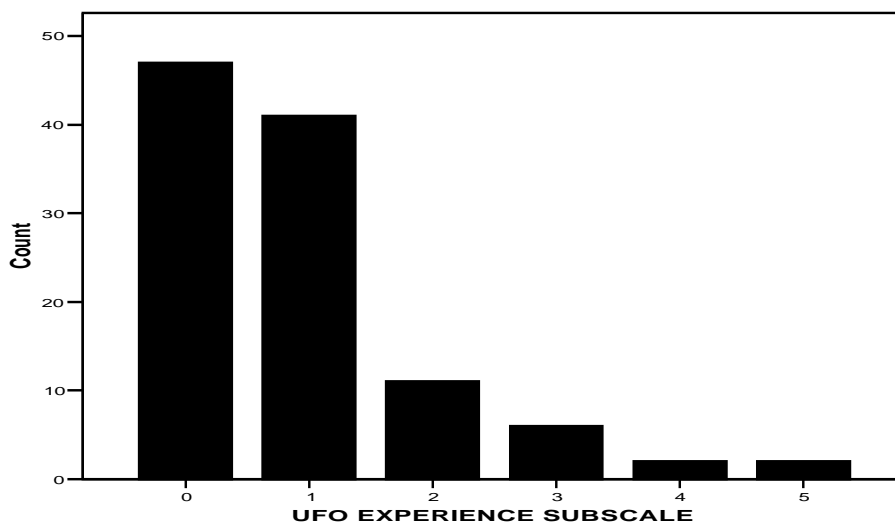


Figure 7.11. Frequency distribution for the Encounters with UFOs Experience Subscale.

For nine of the ten subscales, the distribution of affirmative responses yielded acceptable to highly satisfactory internal reliability coefficients, as measured by Cronbach's alpha. The exception was the Close Encounters with UFOs Subscale, which was discussed above. Normality of distribution was observed in four cases (viz., Dark Night Subscale, the Kundalini Subscale, the Near-Death Subscale, and the Central Archetype Subscale), whereas in the six other subscales there was significant skewness of scores and/or significant kurtosis. It must be borne in mind that persons thought to

have had a spiritual emergency were specifically invited to participate in this questionnaire study, and so, if the subscales are valid, the subscale mean scores may be somewhat higher than for a sample drawn at random from the population.

Though it is considered that the attempt to construct apparently appropriate and face valid measures of ten spiritual emergencies has been largely successful, it must be emphasised that, with the exception of the EPSS, the empirical validity of these ten scales have not been evaluated. For example, is it indeed the case that persons who have experienced a near-death experience actually score higher than a nonexperient on the Near-Death Experience Subscale? The research thus far does not address such questions, and for that reason the results must be regarded as tentative. The empirical validity question is considered very important but beyond the scope of this thesis. In the meantime, it is concluded that self-reports of spiritual emergency phenomena have been successfully measured.

Results of a Pearson Correlation Analysis

Table 7.3 contains the inter-correlations between the ten spiritual emergency subscales together with their correlation with the EPSS and the Lie Scale.

Considering first the Lie Scale, in order to see whether the data is contaminated by social desirability responding, 10 of the 11 coefficients observed were nonsignificant. It seems likely that the sole significance in this list (with UFO experience) is probably due to multiple analysis artifact or

Table 7.3

Inter-correlations for the 10 Spiritual Emergency Subscales Plus Experience of Psychotic Symptoms and the Lie Scale

Scale	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.
1. Dark Night		.54	.53	.51	.56	.35	.36	.55	.53	.21	.68	-.14
2. Kundalini			.73	.57	.65	.58	.61	.67	.72	.39	.68	.08
3. Shaman				.79	.80	.62	.72	.64	.80	.41	.66	.01
4. Peak					.76	.45	.63	.44	.64	.28	.50	.07
5. Psychic						.64	.67	.54	.71	.32	.67	.01
6. Past-Life							.58	.50	.62	.36	.48	.10
7. NDE								.43	.58	.52	.52	.12
8. Possession									.71	.34	.71	-.02
9. Central										.38	.69	.05
10. UFO											.33	.20
11. Psychotic												-.09
12. Lie Scale												

Note: All correlations are significant at $p < .001$, except for three mentioned in the text.

problems with the subscale. It is concluded that social desirability appears not to have influenced the great majority of subscale-scores.

Next, the correlations with the EPSS are considered. Inspection of Table 7.3 shows that all ten correlations are positive and significant, ranging from a low of .33 with UFO experience, to .71 for "Possession". In general the relationships between spiritual emergency subscale and the EPSS are rather strong.

Finally, the 10 x 10 matrix of correlations for the ten spiritual emergency subscales is considered. Again it is noted that all the correlations are positive and most of them are high, ranging from a low of .21 ($p = .027$), between UFO experience and Dark Night, to .80, between Shamanic Crisis and both Psychic Opening and the Activation of the Central Archetype. All 45 correlations were significant at $p < .001$ except a handful (3 with the UFO subscale), which were not significant at the .001 level but only the .05 level. Because 32 of the subscales were highly correlated with each other ($r \geq +0.50$), it must be acknowledged that they may not be independent of each other.

7.3: Relationship between the SE Subscales, Religiosity and Spirituality

Descriptive data were obtained on five additional variables: (1) self-reported religiosity (17% yes, 83% no); (2) self-reported spirituality (88% yes, 12% no); (3) method of spiritual practice (44% meditation, 12% awareness, 5% prayer, 5% yoga, 16% "various", 18% "other"); (4) frequency of spiritual practice (12% all the time, 65% daily, 8% more than one a week, 5% weekly, 10% occasionally); and (5) how many years have you been on the spiritual

path? (6% 0-2 years, 10% 3-5 years, 16% 6-10 years, 68% more than 10 years).

The EPPS was examined in relation to these five variables. In the case of all these five variables, Univariate Analysis of Variance indicated that those variables were not significantly related to level of scoring on the EPSS.

The scores on the ten spiritual emergency subscales, the EPSS, and the Lie Scale were examined in relation to self-reported religiosity and self-reported spirituality.

First, just 19 persons out of the total of 109 reported themselves to be religious. A comparison with the 90 self-reported nonreligious persons yielded not a single significant difference. Self-reported religiosity appears to be unable to predict (or prevent) the experience of a spiritual emergency.

Second, 96 people self-reported as spiritual, just 13 saying they were not. Out of 12 comparisons, five were clearly significant, and one (Kundalini) was marginally significant. The results for these six subscales may be found in Table 7.4.

Spiritual persons scored significantly higher than Nonspiritual persons on Shamanic Crisis, Peak Experience, Psychic Opening, Past-Life Experience, and the Central Archetype, and marginally higher on Kundalini. However, a caution must be made, inasmuch as the amount of variance explained is in each case rather low, generally less than 10%. A second caution is that it is not known whether spirituality leads to the experiencing of spiritual emergency, or whether experience of spiritual emergency leads to spirituality. Future studies of spiritual emergency might ask the person whether there appeared to be a pronounced *increase* in spirituality following the emergency.

Table 7.4

Comparison of Spiritual Versus Nonspiritual Participants for Six Spiritual Emergency Subscales

	Spiritual (<i>N</i> = 96)		Nonspiritual (<i>N</i> = 13)		<i>F</i> (1, 107)	<i>p</i>	Partial η^2
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Kundalini	4.55	2.81	2.92	2.96	3.80	.054	.034
Shaman	5.03	2.54	2.46	2.88	11.36	.001	.096
Peak	5.36	1.95	3.46	2.57	10.10	.002	.086
Psychic	8.49	3.15	5.15	3.63	12.42	.001	.104
Past-Life	2.43	1.70	0.85	1.28	10.37	.002	.088
Central	3.74	2.39	1.77	2.68	7.56	.007	.066

Protective Factors and Spiritual Emergency

The presence of self-reported religiosity or spirituality as protection from experiencing a psychotic-like spiritual emergency was examined. The sample was divided into four groups: (1) religious and spiritual ($n = 17$), (2) religious but not spiritual ($n = 2$), (3) not religious but spiritual ($n = 79$), and (4) neither religious nor spiritual ($n = 11$). Pearson correlations were calculated between the EPSS and the 10 Spiritual Emergency scales for three of the four groups (group 2 was too small for such an analysis).

The differences between the three groups were analysed using Friedman Analysis of Variance, supplemented by Wilcoxon tests: group 3 (spiritual but not religious) gave the lowest average correlation (viz., 0.544), whereas group 1 (religious and spiritual) gave a rather higher average

correlation (viz., 0.674), and group 4 (neither religious nor spiritual) gave the highest mean correlation (viz., 0.764), comparison of which gave a significant difference, $\chi^2(2, N = 10) = 9.80, p = .007$. The Wilcoxon test gave significant differences between all three means taken as pairs.

Thus, for group 4 (neither religious nor spiritual) the correlations between the EPSS and the ten Spiritual Emergency Scales are the highest, and suggest that the various spiritual emergencies tend to be very good predictors of number of psychotic symptoms in group 4, and vice versa. However, members of group 1 (religious and spiritual) and of group 3 (spiritual and not religious) who score highly on number of psychotic symptoms are not as likely to score high on the ten spiritual emergency scales. These results suggest that self-reported spirituality (and to a lesser extent religiosity) may exert a somewhat protective effect on the person, and that there is less likely to be a connection between score on spiritual emergency and number of psychotic symptoms.

7.4: Psychotic Episodes and Medication

The validity of the EPSS was then tested by examining its scores in relation to three measured variables: (1) Have you ever experienced what is commonly known as a psychotic episode?⁴⁵; (2) Were you prescribed any kind of medication?; and (3) Were you actually *taking* any medication? If the EPSS is in fact measuring such experiences, scores would be higher in people who report having had a psychotic episode, and/or were prescribed

⁴⁵ It is emphasized that this measure is a self-report item so it cannot be concluded that these people did in fact experience clinical psychosis.

medication, and/or were actually taking medication. Statistics for these three variables are found in Table 7.5.

Table 7.5

Comparison of Scores on Experience of Psychotic Symptoms Scale for Three Psychosis Indicators

<i>Category</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>F(1,98)</i>	<i>p</i>	<i>partial η^2</i>
Reported psychosis	20	10.75	2.71			
Did not report psychosis	80	5.96	3.33	35.42	< .001	.27
Prescribed medication	15	9.93	3.85			
Not prescribed medication	82	6.24	3.42	14.18	< .001	.13
Took medication	20	9.35	3.57			
Took no medication	80	6.31	3.54	11.73	.001	.11

It may be concluded from the results in this table that scores on the EPSS are significantly higher in persons who report having experienced psychosis, having been prescribed medication, and who actually took medication. It should be noted that the amount of variance explained by these three indicators is between 11% and 26%, and is therefore low to moderate. It is concluded that the EPSS shows some empirical validity.

7.5: A Spiritual Emergency Scale

Construction of the scale: As planned, steps were then taken to construct a Spiritual Emergency Scale (SES) possessing fewer items than the original Questionnaire.

Factor Analysis

First, because of the high degree of interrelatedness of the ten spiritual emergency subscales, it was appropriate to subject them to principal components factor analysis. The analysis yielded just a single component, with an Eigenvalue of 6.10 that accounted for 60.97% of the variance. This single component was called “Spiritual Emergency”.

The factor loadings and communalities can be found in Table 7.6, where it can be seen that the greatest contribution was made by the Shamanic Crisis Subscale and the least by the Experience of UFO Encounters.

Note that each participant can be assigned a factor score representing his or her position in the distribution of factor scores ($M = 0.00$, $SD = 1.00$, minimum = -1.80 , maximum 2.19). These factor scores were correlated with the EPSS, resulting in $r(107) = .76$, $p < .001$, indicating a very strong relationship between the two. Moreover, self-reported spiritual participants (but not religious persons) scored significantly higher on this factor score ($M = 0.10$, $SD = 0.95$) than did nonspiritual participants ($M = -0.77$, $SD = 1.09$), $F(1, 107) = 9.35$, $p = .003$, partial $\eta^2 = .080$, a rather small effect.

Table 7.6

*Factor Loadings and Communalities for the Ten Spiritual Emergency
Subscales*

Subscale	Factor loading	Communality
Shamanic Crisis	.919	.845
Central Archetype	.870	.758
Psychic Opening	.869	.755
Kundalini	.838	.702
Peak Experience	.794	.630
Near-Death Experience	.785	.616
Possession	.750	.563
Past-Life Recall	.734	.539
Dark Night	.654	.428
UFO Experience	.510	.260

Second, the 84 items of the Questionnaire were each correlated with the factor score. Thirty items were chosen as correlating highest with that factor score: these items were Q3, Q12, Q14, Q16, Q18, Q21, Q28, Q29, Q31, Q50, Q52, Q56, Q57, Q61, Q67, Q68, Q69, Q72, Q74, Q75, Q79, Q81, Q83, Q84, Q85, Q89, Q90, Q100, Q103 and Q106. It is noted that Shamanic Crisis—which loaded most heavily in the factor analysis—also contributed the most questions (viz., 7). Psychic Opening contributed 6, Peak Experiences 5, Central Archetype 4, 3 each for Kundalini and “Past Life” Experience, and 1 each for Dark Night and Possession. There was no contribution from Near-Death Experience or UFO Encounter. Figure 7.12 displays the frequency distribution for the scores on the SES.

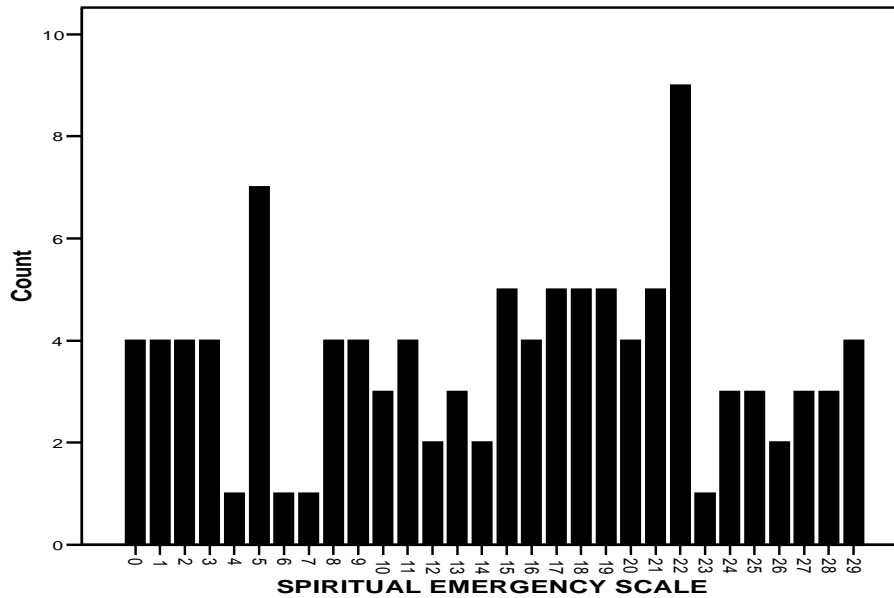


Figure 7.12. Frequency distribution for the Spiritual Emergency Scale.

It can be seen that, rather than being normally distributed, the scores show an approximately rectangular or flat distribution.

The theoretical range of scores is 0-30. As can be seen from Figure 7.12, the minimum score was 0 and the maximum 29. The mean score was 14.72 ($SD = 8.52$) (halfway between minimum and maximum), the median was 16.00.

Whereas skewness was normal, there was a significantly negative value for kurtosis, $z = -2.40$, $p = .016$ (two-tailed) indicating a flatter than normal distribution, though it is not known why a normal distribution did not occur. Corrected inter-item correlations ranged from .47 to .72, and all items contributed to the Scale. Cronbach's alpha was a very high .94. By the criterion of one standard deviation above the mean, it may be deduced that scores of 23 and above suggest the experience of either spiritual emergency or psychosis, though exactly of what type of spiritual emergency requires

further probing, perhaps by clinical interview, or by administering the full complement of subscales and studying the results of each. Alternatively, the test-administrator can examine which items were answered affirmatively and thereby identify the relevant subscales.

Relation of the Spiritual Emergency Scale to the Experience of Psychotic Symptoms Scale: The Pearson correlation between the EPSS and the new Spiritual Emergency Scale was highly positive and significant, $r(107) = .70$, $p < .001$, two-tailed. Some researchers would conclude that the two scales are measuring essentially the same thing. This issue is raised again in the Discussion.

Relation of the Spiritual Emergency Scale to indicators of psychosis: The results of Analysis of Variance, comparing scores on the SES in relation to self-reports of experience of psychosis, being prescribed medication, and actually taking medication, may be found in Table 7.7.

It can be seen from Table 7.7 that people who report themselves as having experienced psychosis ($N = 20$) also score high on the SES, though the effect size is not large.

It can also be seen also that persons prescribed medication ($N = 15$) score marginally higher on the SES than persons not so prescribed, and thus the effect size is very weak. Finally, there is a statistically significant difference between the mean SES scores of persons ($N = 20$) actually taking (as opposed to not taking) some form of medication, but the effect size is very low.

Table 7.7

Comparison of Scores on the Spiritual Emergency Scale for Three Psychosis Indicators

Category	<i>N</i>	<i>M</i>	<i>SD</i>	<i>F</i> (1,04)	<i>p</i>	partial η^2
Reported psychosis	20	20.85	6.06			
Did not report psychosis	80	13.49	8.33	35.42	< .001	.27
Prescribed medication	15	18.33	7.36			
Not prescribed medication	91	13.90	8.62	3.53	.063	.03
Took medication	20	18.55	7.81			
Took no medication	89	13.85	8.48	5.15	.025	.05

The Spiritual Emergency Scale appears to function in a way similar to that of the EPSS (with which it correlates very highly), inasmuch as persons who score high on the former tend also to report experience of psychosis, as well as the taking of medication. However, the effect sizes, as given by partial η^2 , suggest that the associations with these psychosis-indicators are very weak.

CHAPTER 8: DISCUSSION

8.1 Discussion of Results

Ten questionnaire subscales with a total of 84 items were developed to measure ten different types of so-called spiritual emergency, from which was compiled the Spiritual Emergency Scale (SES). Also developed was a 15-item Experience of Psychotic Symptoms Scale (EPSS). One hundred and nine individuals from the general public in Australia were administered the spiritual emergency subscales, together with the EPSS, three validity questions relevant to psychosis, and a lie scale. All the resultant ten subscales were psychometrically acceptable except for the UFO Experience subscale. All ten subscales correlated significantly, positively and highly with the EPSS.

To make it easier for the mental health professional, cutoff scores were provided for each spiritual emergency subscale, at or above which an individual may be said to have experienced such an emergency, as well as providing an indicator of the presence of psychotic symptoms. Persons scoring at or above the cutoff were in every case on these subscales found to have EPSS scores significantly higher than persons scoring below the cutoff. The given cutoffs might therefore be of clinical utility in designating persons whose spiritual emergency is characterised by a high degree of psychoticism, or whose is psychoticism characterised by a high degree of spiritual emergency.

The subscales inter-correlated positively and highly, and factor analysis revealed a single factor underlying the subscales that was termed “spiritual emergency.” This factor correlated .76 with experience of psychotic symptoms

(measured on the EPSS). Factor-scores and the original 84 items were used to create a 30-item SES, which was internally reliable, and had reasonable psychometric properties. Likewise, the SES correlated highly with the EPSS ($r = .70$) and with two of the three psychosis-indicators.

With such a high correlation between the spiritual emergency subscales and the experience of psychotic symptoms, we need to consider whether these scales are actually measuring the same process. If so, the differential diagnosis between psychosis and spiritual emergency will be extremely difficult and we will need to investigate each of these experiences in more depth and detail than has been covered in the current scales.

We may also need to investigate what other factors, not measured in the scales, play a role in determining the difference between the two. In fact, further analysis revealed that spirituality was not constant across the levels of religion. There may be no strong evidence that a spiritual or religious attitude/disposition protects against, or predicts, psychosis, but it appears that there are those in the sample who may define religion in a limited, strictly denominational, sense (the high-correlation group: spiritual/religious), whereas those who are spiritual/non-religious (low-correlation group) see spirituality as something other. As long as spirituality is viewed differently according to religious outlook, it cannot be said how the practice of a spiritual attitude manifests in the two different groups. In causal terms, either (i) religiosity/spirituality *together* are not protective from the beginning (before psychosis onset), or (ii) psychosis, if severe enough, leads *some* sufferers towards religio-spiritual pursuits because they think these will alleviate their symptoms, but they fare no better than those who are non-spiritual *and* non-

religious. The exception is the low-correlation group (spiritual/non-religious), which suggests pure spirituality (i.e., no religious influence). Their spiritual emergency data were not as strongly associated with psychotic symptoms as were the other groups. It is as if this 'pure' form of spirituality may predict *against* psychosis.

If we consider the spiritual/non-religious group as sharing similarities with the mystical experiences groups as presented in Chapter 5, then our limited findings go some way in supporting those reported in the literature. Buckley's (1981) analysis outlined a number of differences between people reporting mystical experiences (M's) and people experiencing psychosis (P's) including; M's turn their attention inward and are able to perceive the 'self' as 'subject' as separate from mental content, whereas P's experience confusion, anxiety and emotionality, and less ability to maintain equanimity; M's display no disruption of thought or disturbance in language and speech, whereas P's display disruption of thought and disturbance in language and speech; M's display appropriate affect, whereas P's display flatness of affect; M's exhibit no socially disturbing behaviour, whereas P's exhibit some self-destructive acts as well as aggressive and sexual outbursts.

Similarly, Brett (2002) revealed that during the mystical experience one's attention is turned inward, the 'process of perception' becomes the focus of attention and perceptions are passively experienced, leading to non-identification of these mental events. Although the psychotic state also exhibits a shift of attention away from practical, social and sensorimotor activity, the ego is maintained and there is a loss of distinction between the subjective and objective worlds.

These researches suggest that a possible predictor for these differences in experience may lie within the variance of spiritual or religious understanding or practice. Others have suggested that the differences may lie in ones understanding of the process. For example, Wilber (1980) described the 'schizophrenic' experience as a regression in the service of ego, an overwhelming process of contacting past and infantile experiences, often occurring against one's will. In contrast, the 'mystic' is exploring the same inner realms of the 'schizophrenic', but they are following a carefully mapped out path in order to master contact with past and present depths of reality. In a similar way, Campbell (1972) recognised that the mystic is endowed with native talents and, following the instructions of a master, is able to navigate their inner world, whereas the mentally ill enter the terrain unprepared and unguided, and are unable to cope with the unusual phenomena.

Further results from this research clearly demonstrated that individuals scoring high on the spiritual emergency subscales also scored high on the EPSS, thus indicating that these individuals experience symptoms associated with both psychosis and spiritual emergency. Moreover, those individuals reporting a greater number of spiritual emergency symptoms (i.e., scoring above the cutoff scores) also reported a greater number of symptoms on the EPSS. In addition, the single factor underlying the subscales not only correlated highly with the EPSS, but also correlated with two of the psychosis indicators.

These findings clearly demonstrate a strong relationship between self-reported experiences of many psychotic symptoms, self-reports of psychosis, and spiritual emergency, to such an extent that suggests that they may be

different aspects of the same process, relative of course to the construct validity of the scales/subscales used. On that basis, we may still need to develop diagnostic methods that discriminate the subtle differences between psychosis and spiritual emergency, as the current diagnostic methods (i.e., differentiation via form, content, relationship with other symptoms, and reference to the descriptive criteria for mental illness) have been unable to do so. Although much of the spiritual and psychotic phenomena are qualitatively identical, a number of distinctions between the phenomena have been recognised as dependent on the way in which psychotic phenomena themselves are embedded in the values and beliefs of the experiencer (Jackson & Fulford, 1997). As already suggested, and insofar as there is so much congruence between spiritual and psychotic phenomena, is it possible, in spite of the differences, that spiritual emergency and psychosis are describing the same human condition interpreted through different worldviews? In the West we tend to pathologise deviant behaviour or symptoms we don't understand, and to date, not having a thorough understanding of the psychotic process, it is viewed as a mental illness. To illustrate this point, Brett (2002) explains how the sense of rebirth or awakening experienced by both the 'yogi' and the 'psychotic' are interpreted differently depending on the adopted worldview. From the yogic worldview, the process can be taken literally as a spiritual rebirth or awakening, whereas from the western medical worldview this same process maybe interpreted as delusional.

Is it possible that the psychotic episode is not in itself the illness that needs to be healed but rather, *is* in itself the healing process? In the same

sense, the Shamanic initiation crisis, or the rising of Kundalini, may look like psychotic episodes to psychiatrists in the West, yet these are seen as beneficial, though nonetheless considered, in the relevant cultures, to be arduous growth processes.

Moreover, if there are no biological markers for psychosis, how is it warranted that psychosis can be classified by the medical profession as a mental condition, disorder, or even an illness? Why can it not be viewed as a psychospiritual crisis? In fact, given the results of this research, some might argue that spiritual emergency is nothing more than psychosis, whereas others might equally argue that psychosis is nothing more than spiritual emergency.

Given the difference in interpretation, it seems that until we have a thorough understanding of psychosis and spiritual emergency, at the very least, it is most important to distinguish a 'standard' psychotic episode from a psychotic episode offering the potential of positive growth. As reported elsewhere in this thesis, psychotic disorders with the potential for a positive outcome have been well recognised in the psychiatric literature and guidelines have been proposed to assist the clinician with this differentiation (Grof & Grof, 1986, 1989; Lukoff, 1985).

8.2 Limitations of the Thesis

This thesis spanned across several disciplines including psychiatry, psychology, transpersonal psychology, theology, mythology, anthropology and sociology. Each of these areas of inquiry has their own language and classification system in which to describe certain phenomena. Even within

each of these disciplines there is often debate among scholars, especially in the area of psychiatry, in relation to the validity of their classification systems.

There is the possibility and probability that in collating information from such a vast pool of disciplines, without an in-depth understanding of each, that important and vital information has been neglected, thus not representing the information taken from these fields with precision. This may be especially true in relation to cross-cultural studies in which the researcher may not share the same worldview as the population they are studying and thus report with unintentional bias. In this situation, the information reported in this thesis will also carry the possibility of this bias.

There is limited empirical scientific research in the area of spiritual emergency. A great deal of research is anecdotal and is drawn from a wide variety of disciplines. Most of the phenomena making up the various sub-types of spiritual emergency are relegated to the fringe sciences, and even considered pseudo-science, by the mainstream psychiatric profession and therefore have not been considered worthy of, or appropriate for serious scientific enquiry. However, in order to make advances within the field of psychiatry and psychology, it is these phenomena that lie at the fringe of the profession, unexplainable by the current scientific model, which must be investigated if we are to understand the true nature of many mental disorders and their purpose.

8.3 Contribution to the Field

At the heart of this research lies a substantial literature review exploring the concept of “spiritual emergency”. There is considerable support from

cross-cultural and cross-disciplinary research, in favour of viewing certain types of personal crises as developmentally healthy rather than psychopathological. This literature review led to the development of the SES.

One of the initial aims of this research was to compile questionnaire measures of Experience of Psychotic Symptoms and ten Spiritual Emergency Subscales. The exercise has been successful, as shown by a number of statistical indicators. The one subscale that had poor psychometric properties was the Experience of UFO Encounters Subscale, to which almost no one gave affirmative responses, but this result is perhaps not surprising given that UFO encounters are one of the rarest of the rare phenomena that are the subject of this thesis.

The ten subscales now need to be validated using appropriate samples and criterion groups.

Another achievement of this research was the development of a Spiritual Emergency Scale. This scale was strongly correlated with experience of psychotic symptoms. However, a drawback of the Scale is that it does not in itself tell us which spiritual emergency has taken place in the respondent, and despite the factor analysis we may want to retain such information. The scale acts as a generalised pointer to the occurrence of one or more of the spiritual emergencies in the person's history.

8.4 Suggestions for Future Research

In this thesis, no progress was made concerning the variables indicative of successful resolution of the spiritual emergency, namely, the spiritual emergence phenomena of "increased creativity, feelings of peace,

and an expanded sense of compassion” (Thalbourne, 2003, p. 118). In future research a distinction should be made between current emergency and past emergency, with the prediction that the person who has experienced a spiritual emergency in the past will exhibit more of these indicators. It is conceivable that spiritual emergency results in creativity, peacefulness and compassion, whereas psychosis does not, or at least not to the same extent, and this would be one or more points of difference between them.

There was difficulty in this research in distinguishing between psychosis and spiritual emergency. For future research the hypothesis that people with psychosis are a sub-group of those experiencing spiritual emergency is suggested. The rest of these people would not be suffering from psychopathology. An important way of drawing out a distinction between these two sub-groups would be to test them for the presence of protective factors that might provide a buffer for the non-pathological group from the pathological effects of psychosis that require medication and other clinical treatment.

There are many possible protective factors, each of which could serve as possible predictors of a difference between people having psychosis and people having only spiritual emergency: the latter may have what Jung would call a “strong ego-complex”, and/or strong social support, such as family, or spiritual community as well as innate and learned resilience factors, which may or may not include a capacity to draw symbolic insights from psychosis as opposed to acting on them literally. Such support and resilience may help channel the powerful archetypal forces that swamp the victim so much so that they would have been considered psychotic if not for the support they have in

place. It may reasonably be concluded that spiritual emergency is present to varying degrees in large proportions of the population, but not psychosis, because the experiences of emergency—to whatever degree—are “managed”.

No questionnaire can ever be considered 'exhaustive', and any attempt to do so should be avoided if the participant will be unreasonably burdened by an unnecessarily lengthy questionnaire. However, in the case of the revised 30-item questionnaire, extra items measuring possible protective factors, which may further differentiate psychotic symptoms and SE would be an improvement. It would also be beneficial for future research to explore the correlations of the SES in a large normal population sample.

8.5 Conclusion

The aim of this thesis was to present an emerging theoretical framework for viewing certain types of personal crises as developmentally healthy rather than as psychopathological. These types of crises are described as psychospiritual or "spiritual emergency". Within this paradigm, spiritual emergence and spiritual emergency are viewed as signs of transitional, personal growth rather than symptoms of psychopathology, and need to be differentiated accordingly.

Mainstream psychiatry currently makes no distinction between psychospiritual crisis and psychopathology. In general, psychiatry also indiscriminately dismisses a number of great spiritual traditions and their contribution to our understanding of the nature of the psyche, even though these ancient disciplines are believed to be based on centuries of deep psychological exploration and experimentation. With little understanding and

recognition of the spiritual and mystical traditions in the west, the emergence of associated elements arising in the midst of the psychospiritual crisis are often seen as frightening or threatening. The mystical or spiritual content as well as the non-ordinary states of consciousness that often occur during the crisis are automatically put in the category of mental illness and treated accordingly. The insensitive use of psychiatric labels and the various repressive measures commonly used in psychiatric treatment can interfere with the healing potential of the spiritual emergency and present an unfortunate contrast to those situations where an individual's psychospiritual healing process is supported and enabled to reach completion (Grof & Grof, 1989, 1991).

Even if the concept of spiritual emergency is not accepted within psychiatry, the statistical significance between the self-reported measures of psychosis and the measures of spiritual emergency are too great to be ignored. At the very least, psychiatrists need to be informed of the potential healing capacity of "spiritual emergency", which shares many similar symptoms with psychosis.

It seems that, in current clinical practice, rather little attention tends to be paid to the *content* of the psychosis; rather, most of the content is coarsely classified (e.g., as "delusions of grandeur") and attempts are then made to administer anti-psychotic medication as quickly as possible. There may instead be benefits if the clinician probes the detail of the ideational and affective content of the psychosis, on the grounds that, rather than being simply the random products of a dysfunctional brain, the content may conform to one of the patterns displayed by spiritual emergency.

Psychosis—so often dismissed as useless—might then be seen as the brain’s attempt to heal itself. It seems to us that the clinician’s role is to aid in that attempt to heal, and not simply by administering medication, but also by trying to descry whether there is a pattern to the psychosis, which, once found, may respond rather better to talk therapy than it does at present. In the current scientific climate, there seems to be a number of factors holding back the exploration of content in the psychotic experience and until the psychiatric profession moves beyond its current limited reductionist framework there will be no recognition of the positive potential in the ‘psychotic’ process.

Although the literature has demonstrated a number of similarities and differences between spiritual emergency and psychosis, this research *identified*, or at the very least *admits to*, an openness to interpretation as to whether psychosis is nothing more than spiritual emergency, or vice versa. Notwithstanding the phenomenological differences pointed out by Buckley (1981) and Brett (2002), these differences seem to be subtle, though they may not necessarily lie within the experience itself. Rather, so-called difference may be largely dependent on the worldview that is adopted in order to describe and understand the processes involved, as pointed out by Wilber (1980) and Campbell (1972). Whichever viewpoint is adopted, there is clearly a closer link between the two phenomena than has previously been thought.

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APPENDIX 1

EXTRAORDINARY PHYSICAL, MENTAL AND SPIRITUAL EXPERIENCES

It has been reported that many people undergo physical, mental or spiritual experiences that are somehow different to their every day level of functioning. For example; seeing oneself from out of your physical body, knowing that something has happened before it has actually taken place, experiencing profound feelings of peace and bliss or perhaps seeing, hearing or smelling things that no one else can.

Over the past forty years, certain areas such as “out of body” experiences and “near-death” experiences have received much worldwide research and attention, which has brought them into our everyday language and understanding.

More recently, Stanislav and Christina Grof undertook pioneering work into what they have termed “spiritual emergency”. They claim that humans have the potential to move toward a more expanded way of being that involves enhanced emotional and psychological health, greater freedom of personal choices, as well as a deeper connection with other people, nature, and the cosmos. This “awakening” can be a slow and gently unfolding realisation of one’s greater potential but at times this transformational process may become overwhelming and the person may be thrown into a state of crisis or emergency.

Stanislav and Christina have found that people who are in such a crisis are bombarded with inner experiences that totally challenge their beliefs and their relationship with reality dramatically shifts. They suddenly feel uncomfortable in their formerly familiar world and may find it difficult to meet the demands of everyday life. They may also find it difficult to distinguish their inner visionary world from the external world of everyday reality. Although they believe this process has the potential to be healing, it can often interfere with the everyday functioning of the person.

Because these experiences appear to be out of context with everyday reality they can be terrifying and confusing and some people may believe that they are “loosing their mind”. Stanislav and Christina have found that individuals undergoing a transformative crisis of this kind, have been automatically put in the same category as those with mental illness, treated accordingly and thus miss out on the potential healing benefits of the process. The researcher of this study agrees with their need to clarify the concept of “spiritual emergency” and to develop comprehensive and effective approaches to its treatment.

The present research seeks to investigate a number of extraordinary mental, physical and spiritual experiences, which have been found to occur in the general population. Participation involves answering a 108-item questionnaire, mainly requiring “yes” or “no” answers, as well as a few questions inviting longer responses. The amount of information you disclose is up to you, your name will not be attached to the questionnaire, and the information contained will be held strictly confidential.

It is hoped that by generating research in this area, the level of awareness of these extra-ordinary mental, physical and spiritual experiences will increase. This in turn will hopefully generate more appropriate and compassionate options for care and support.

This project has been approved by the Ethics Subcommittee of the School of Psychology, University of Adelaide. For further information about the content of this research or referrals to counsellors, should you need to debrief, contact Monika Goretzki (0401 049 027; monica.goretzki@adelaide.edu.au). For ethical concerns contact the convenor of the Ethics Subcommittee, Dr. Paul Del Fabbro ((08)8303-5774; paul.delfabbro@psychology.adelaide.edu.au). Please retain this Information Sheet for future reference.

APPENDIX 2

“EXTRA-ORDINARY” EXPERIENCES QUESTIONNAIRE

The following questionnaire contains two sections. The first section aims to collect some general information about you. The second section will be asking for more specific information about your extraordinary (different from usual) mental, physical and spiritual experiences.

This research is seeking information about extraordinary experiences that occur in the natural, un-intoxicated state, so it is important that you **do not include** those instances when you may have been under the influence of drugs.

Some of the questions are similar in content. However, they are necessary, so please bear with the process.

Please choose the answer that best fits your experience by highlighting “Y” for yes, “N” for no or “?” for unsure.

SECTION I

Year of birth:	Sex:	M	F
Do you consider yourself to be a religious person?		Y	N
Do you consider yourself to be a spiritual person?		Y	N
If so, what is your main method of practice? (eg: attending church, meditation, etc.)			
How often do you practice? (eg: daily, once a week, etc.)			
.....			
How many years have you practiced your current spiritual/religious path?			
*Have you ever experienced an extraordinary positive or negative experience that was difficult to describe or understand?		Y	? N
If so, was this in relation to a major life change? (e.g. death in the family, physical/financial stress, divorce, loss of job, etc.)		Y	? N
*Have you ever experienced what is commonly known as a psychotic episode?		Y	? N
*Have you ever experienced a period of rapid personal or spiritual growth that became chaotic or overwhelming?		Y	? N
If you answered “NO” to <u>all three</u> of the above questions with an asteric (*), please go to SECTION II.			

If you answered “YES” to any of the above questions with an asteric (*), when did you have

15.	Do you occasionally have thoughts and ideas that you would not like other people to know about?	Y	N
16.	Have you ever been aware of the presence of spiritual entities or beings?	Y	N
17.	Have you ever felt strange and cut off from the world with everything moving in slow motion?	Y	N
18.	Have you ever lost your sense of reference as your outer and inner worlds dissolved?	Y	N
19.	Have you ever experienced your voice spontaneously taking on a deep and other-worldly quality?	Y	N
20.	Have you ever experienced a 'sacred marriage' or a blissful union with a mythological figure or an idealised person from your own life?	Y	N
21.	Have you ever experienced the spontaneous production of complex visual geometrical images or chants inside your head?	Y	N
22.	Have you ever experienced visions and/or vivid dreams which seemed real even after you "woke up"?	Y	N
23.	Are all your habits good and desirable ones?	Y	N
24.	Have you ever travelled, by non-ordinary means, to a place where the landscape was unlike anything you have ever seen or could imagine on earth?	Y	N
25.	Have you ever experienced a connection with the after-life or communication with your ancestors?	Y	N
26.	Have you ever been really convinced of something being real even though others did not share the same belief?	Y	N
27.	Do you sometimes gossip?	Y	N
28.	Have you ever had the sense of becoming one with humanity, nature, the creative energy of the universe and/or God?	Y	N
29.	Have you ever experienced the spontaneous desire to create rituals?	Y	N
30.	Have you ever made contact with someone whom you believed to be an "extraterrestrial" being?	Y	N
31.	Have you ever been overwhelmed by powerful emotions and physical sensations, concerning yourself and others in various circumstances and historical settings?	Y	N
32.	Have you ever experienced intense involuntary body movements such as shaking, vibrations or jerking for no apparent reason?	Y	N
33.	Would you always declare <i>everything</i> at customs, even if you knew that you could never be found out?	Y	N
34.	Have you ever found yourself desperately trying to make sense of an unfamiliar environment?	Y	N
35.	Have you ever experienced a review of your entire life within moments of ordinary time?	Y	N

36.	Have you ever found yourself out of your physical body?	Y	N
37.	Have you ever seen something that you believed to be a UFO?	Y	N
38.	Have you ever entered an altered state of consciousness where a spirit, power, deity or other being assumed control over your mind and body?	Y	N
39.	Have you ever experienced difficulty in separating powerful, vivid inner experiences from occurrences in the outer world?	Y	N
40.	Have you ever experienced someone outside of yourself controlling your body or actions?	Y	N
41.	Have you ever spontaneously burst into uplifting sacred songs and dances?	Y	N
42.	Have you ever been late for an appointment or work?	Y	N
43.	Have you ever heard voices as distinct from your own coming from inside your head?	Y	N
44.	Have you ever experienced precognition, knowing of an event before it actually occurred?	Y	N
45.	Have you ever been "attacked" by negative energy or entities, exposing you to torture and/or death?	Y	N
46.	Have you ever witnessed physical disturbances such as movements in a house with no apparent physical cause?	Y	N
47.	Of all the people you know, are there some whom you definitely do not Like?	Y	N
48.	Have you ever experienced a state of profound peace and beauty?	Y	N
49.	Have you ever experienced significant difficulties in keeping up with social and/or occupational obligations?	Y	N
50.	Have you ever spontaneously attained profound insights into the nature of reality?	Y	N
51.	Have you ever experienced sensations such as smelling the scent of sandalwood, perfume or incense without knowing where it's coming from?	Y	N
52.	Have you ever undertaken a powerful inner experience that involved a journey into another world?	Y	N
53.	Do you sometimes talk about things you know little about?	Y	N
54.	Have you ever believed that your thoughts were being interfered with in some way?	Y	N
55.	Have you ever spontaneously performed previously unknown yogic postures or hand positions?	Y	N
56.	Have you ever had the ability to move in and out of non-ordinary states of consciousness at will?	Y	N

57.	Have you ever spontaneously received accurate information about things in the past, present or future by “extra-sensory” means?	Y	N
58.	Have you ever been led or taken away by some kind of spacecraft that is unlike anything you have ever seen or could imagine on earth?	Y	N
59.	Have you ever felt cut off from the deeper self, higher power, God, or whatever source you depend on for your strength and inspiration?	Y	N
60.	Have you ever experienced a growing discrepancy between your inner spiritual needs and the widespread materialistic emphasis of our society?	Y	N
61.	Have you ever experienced living what seemed to be another life, in another time and place, in great detail?	Y	N
62.	Have you ever felt that you were in the centre of huge events of great importance for the future of the world?	Y	N
63.	Have you ever felt like you were “stuck in a meaningless cycle of life”?	Y	N
64.	Have you ever had an extraordinary experience that has fundamentally challenged your understanding of reality?	Y	N
65.	Have you ever received the help of an “other worldly” being in order to gain a deeper understanding about life and/or universal laws?	Y	N
66.	Have you ever been “so in touch with the inner processes” of another that you can tell what they’re thinking?	Y	N
67.	Have you ever developed a deep change in consciousness during which you lost contact with everyday reality?	Y	N
68.	Have you ever experienced a visionary state, taking you back through your own history and that of mankind to creation?	Y	N
69.	Have you ever felt a sense of overcoming the usual divisions of the body and mind and reaching a state of complete inner unity and wholeness?	Y	N
70.	Have you ever experienced yourself as the “chosen one” with an important message on a mission to help all of mankind?	Y	N
71.	Have you ever found yourself spontaneously producing previously unknown words or sounds?	Y	N
72.	Have you ever spontaneously gained a greater understanding of the cosmos?	Y	N
73.	Have you ever undergone what you believed to be a scientific or medical examination by an “extraterrestrial” being?	Y	N
74.	Have you ever experienced going beyond your normal understanding of time and space and entered a timeless realm where these categories no longer apply?	Y	N
75.	Have you ever heard voices, music or the repetition of mantras, without knowing where they’re coming from?	Y	N
76.	Have you ever experienced a precognitive dream providing you with formerly unknown information?	Y	N

77.	Have you ever felt that your "internal world" was being played out in the external communication of those around you?	Y	N
78.	Have you experienced your hands or body taking on strange contortions or making involuntary movements?	Y	N
79.	Have you ever experienced insights or visions, in which you received sacred teachings and/or healing abilities in order to help others?	Y	N
80.	Have you ever found your everyday thoughts becoming confused or not joining up properly?	Y	N
81.	Have you ever experienced intense sensations of energy and/or heat streaming along your spine?	Y	N
82.	Have you ever experienced sensations of deep peace, tranquillity, joy, and overwhelming waves of bliss?	Y	N
83.	Have you ever spontaneously lost your sense of identity?	Y	N
84.	Have you ever felt like you have personally witnessed detailed sequences of events taking place in other historical periods and/or cultures that you had no previous exposure to?	Y	N
85.	Have you ever spontaneously attained profound insights into the nature of reality?	Y	N
86.	Have you ever experienced strong instructive intuition?	Y	N
87.	Have you ever experienced seeing, hearing, feeling, smelling or tasting something that no one else could?	Y	N
88.	Have you ever been preoccupied with the theme of death, ritual killing, sacrifice, martyrdom and/or the afterlife?	Y	N
89.	Have you ever been able to see "auras" around people, animals, plants or other living things?	Y	N
90.	Have you ever experienced an increased connection with animals and plants and the elemental forces of nature?	Y	N
91.	Have you ever had an extraordinary experience that has prompted you to change the way you live in a more positive and loving way?	Y	N
92.	Have you ever experienced dramatic episodes of choking, projectile vomiting and/or frantic physical activity?	Y	N
93.	Have you ever experienced a string of events that seemed to be connected at some deeper level?	Y	N
94.	Do you believe that you have lived in another lifetime before this present one?	Y	N
95.	Have you ever experienced great difficulty in organising your thoughts?	Y	N
96.	Have you ever experienced parts of your physical body expanding and/or dissolving?	Y	N
97.	Have you ever experienced powerful waves of emotions, such as anxiety, anger, sadness or joy, for no apparent reason?	Y	N

98.	Has your body ever been “invaded” by a hostile and disturbing energy or entity?	Y	N
99.	Have you ever found yourself outside of your physical body, passing through some kind of dark tunnel?	Y	N
100.	Have you ever been aware of a huge battle being played out between the forces of good and evil or light and darkness?	Y	N
101.	Have you ever experienced a sense of complete and unconditional acceptance, love and forgiveness?	Y	N
102.	Do you believe that some of the difficulties you have had in your life may be due to unresolved conflicts from a previous lifetime?	Y	N
103.	Have you ever experienced the destruction of an old sense of identity followed by rebirth and a renewed purpose for living?	Y	N
104.	Have you ever felt like you were being controlled by an entity or energy with different personal characteristics than your own?	Y	N
105.	Have you ever experienced marked differences in your breathing pattern for no apparent reason?	Y	N
106.	Have you ever experienced a greater awareness of the inter-connectedness of all things?	Y	N
107.	Have you ever found yourself laughing inappropriately or becoming angry or upset without a reason?	Y	N
108.	Have you ever found yourself out of your physical body, moving toward a light of supernatural brilliance?	Y	N

Please check that you answered all of the questions in Section II. This will ensure that your questionnaire is included in the research. Remember to save the questionnaire before sending it back.

Thank you for your patience and invaluable contribution to this research.

APPENDIX 3

LIST OF SCALES AND INCLUDED ITEMS

DARK NIGHT OF THE SOUL (7)

- (5) Have you ever experienced feelings of pressure, claustrophobia or restlessness along with the feeling that part of you is dying?
- (18) Have you ever lost your sense of reference as your outer and inner worlds dissolved?
- (39) Have you ever experienced difficulty in separating powerful, vivid inner experiences from occurrences in the outer world?
- (59) Have you ever felt cut off from the deeper self, higher power, God, or whatever source you depend on for your strength and inspiration?
- (60) Have you ever experienced a growing discrepancy between your inner spiritual needs and the widespread materialistic emphasis of our society?
- (63) Have you ever felt like you were “stuck in a meaningless cycle of life”?
- (96) have you experienced parts of your physical body expanding and/ or dissolving?

THE AWAKENING OF KUNDALINI (11)

- (1) Have you ever experienced spontaneous visions of brilliant or flashing lights?
- (10) Have you ever experienced visions of deities, saints, or mythological beings?
- (21) Have you ever experienced the spontaneous production of complex visual geometrical images or chants inside your head?
- (32) Have you ever experienced intense involuntary body movements such as shaking, vibrations or jerking for no apparent reason?
- (51) Have you ever experienced sensations such as smelling the scent of sandalwood, perfume or incense without knowing where it's coming from?

- (55) Have you ever spontaneously performed previously unknown yogic postures or hand positions?
- (71) Have you ever found yourself spontaneously producing previously unknown words or sounds?
- (75) Have you ever heard voices, music or the repetition of mantras, without knowing where they're coming from?
- (81) Have you ever experienced intense sensations of energy and/or heat streaming along your spine?
- (97) Have you ever experienced powerful waves of emotion, such as anxiety, anger, sadness or joy, for no apparent reason?
- (105) Have you ever experienced marked differences in your breathing pattern for no apparent reason?

THE SHAMANIC CRISIS (10)

- (22) Have you ever experienced visions and/or vivid dreams which seemed real even after you "woke up"?
- (29) Have you ever experienced the spontaneous desire to create rituals?
- (41) Have you ever spontaneously burst into uplifting sacred songs and dances?
- (45) Have you ever been "attacked" by negative energy or entities, exposing you to torture and/or death?
- (52) Have you ever undertaken a powerful inner experience that involved a journey into another world?
- (56) Have you ever had the ability to move in and out of non-ordinary states of consciousness at will?
- (67) Have you ever developed a deep change in consciousness during which you lost contact with everyday reality?
- (79) Have you ever experienced insights or visions, in which you received sacred teachings and/or healing abilities in order to help others?
- (85) Have you ever spontaneously attained profound insights into the nature of reality?
- (90) Have you ever experienced an increased connection with animals and plants and the elemental forces of nature?

UNITIVE EXPERIENCES (7)

- (3) Have you ever had the experience of dealing with something that has a divine nature and is radically different from your ordinary perception of the everyday world?
- (28) Have you ever had the sense of becoming one with humanity, nature, the creative energy of the universe and/or God?
- (48) Have you ever experienced a state of profound peace and beauty?
- (50) Have you ever spontaneously attained profound insights into the nature of reality?
- (69) Have you ever felt a sense of overcoming the usual divisions of the body and mind and reaching a state of complete inner unity and wholeness?
- (74) Have you ever experienced going beyond your normal understanding of time and space and entered a timeless realm where these categories no longer apply?
- (82) Have you ever experienced sensations of deep peace, tranquillity, joy, and overwhelming waves of bliss?

EXPERIENCES OF PSYCHIC OPENING (13)

- (6) Have you ever experienced a greater awareness of your own potential?
- (16) Have you ever been aware of the presence of spiritual entities or beings?
- (44) Have you ever experienced precognition, knowing of an event before it actually occurred?
- (46) Have you ever witnessed physical disturbances such as movements in a house with no apparent physical cause?
- (57) Have you ever spontaneously received accurate information about things in the past, present or future by “extra-sensory” means?
- (66) Have you ever been “so in touch with the inner processes” of another that you can tell what they’re thinking?
- (72) Have you ever spontaneously gained a greater understanding of the cosmos?

- (76) Have you ever experienced a precognitive dream providing you with formerly unknown information?
- (83) Have you ever spontaneously lost your sense of identity?
- (86) Have you ever experienced strong instructive intuition?
- (89) Have you ever been able to see “auras” around people, animals, plants or other living things?
- (93) Have you ever experienced a string of events that seemed to be connected at some deeper level?
- (106) Have you ever experienced a greater awareness of the interconnectedness of all things?

PAST-LIFE EXPERIENCES (5)

- (31) Have you ever been overwhelmed by powerful emotions and physical sensations, concerning yourself and others in various circumstances and historical settings?
- (61) Have you ever experienced living what seemed to be another life, in another time and place, in great detail?
- (84) Have you ever felt like you have personally witnessed detailed sequences of events taking place in other historical periods and/or cultures that you have had no previous exposure to?
- (94) Do you believe that you have lived in another lifetime before this present one?
- (102) Do you believe that some of the difficulties you have in your life may be due to unresolved conflicts from a previous lifetime?

NEAR-DEATH EXPERIENCES (8)

- (35) Have you ever experienced a review of your entire life within moments of ordinary time?
- (36) Have you ever found yourself outside of your physical body?
- (64) Have you ever had an extraordinary experience that has fundamentally challenged your understanding of reality?
- (65) Have you ever received the help of an “other worldly” being in order to gain a deeper understanding about life and/or universal laws?

- (91) Have you ever had an extraordinary experience that has prompted you to change the way you live in a more positive and loving way?
- (99) Have you ever found yourself out of your physical body, passing through some kind of dark tunnel?
- (101) Have you ever experienced a sense of complete and unconditional acceptance, love and forgiveness?
- (108) Have you ever found yourself out of your physical body, moving toward a light of supernatural brilliance?

SPIRIT POSSESSION (8)

- (7) Have you ever experienced your eyes and face spontaneously taking on wild and/or terrifying expressions?
- (12) Have you ever had the need to fight off or try to control the actions of a negative being or entity?
- (19) Have you ever experienced your voice spontaneously taking on a deep and otherworldly quality?
- (38) Have you ever entered an altered state of consciousness where a spirit, power, deity or other being assumed control over your mind and body?
- (78) Have you experienced your hands or body taking on strange contortions or making involuntary movements?
- (92) Have you ever experienced dramatic episodes of choking, projectile vomiting and/or frantic physical activity?
- (98) Has your body ever been “invaded” by a hostile and disturbing energy or entity?
- (104) Have you ever felt like you were being controlled by an entity or energy with different personal characteristics than your own?

PSYCHOLOGICAL RENEWAL THROUGH THE CENTRAL ARCHETYPE (9)

- (14) Have you ever experienced rich connections with mythological symbols from ancient history?

- (20) Have you ever experienced a 'sacred marriage' or a blissful union with an imaginary mythological figure or an idealised person from your own life?
- (25) Have you ever experienced a connection with the after-life or communication with your ancestors?
- (62) Have you ever felt that you were in the centre of huge events of great importance for the future of the world?
- (68) Have you ever experienced a visionary state taking you back through your own history and that of mankind to creation?
- (70) Have you ever experienced yourself as the “chosen one” with an important message on a mission to help all of mankind?
- (88) Have you ever been preoccupied with the theme of death, ritual killing, sacrifice, martyrdom and /or the afterlife?
- (100) Have you ever been aware of a great battle being played out between the forces of good and evil or light and darkness?
- (103) Have you ever experienced the destruction of an old sense of identity followed by rebirth and a renewed purpose for living?

UFO EXPERIENCES (6)

- (8) Have you ever been led or taken away by someone who you believed to be an extraterrestrial being?
- (24) Have you ever travelled, by non-ordinary means, to a place where the landscape was unlike anything you have seen or could imagine on earth?
- (30) Have you ever made contact with someone whom you believed to be an “extraterrestrial” being?
- (37) Have you ever seen something that you believed to be a UFO?
- (58) Have you ever been led or taken away by some kind of spacecraft that is unlike anything you have seen or could imagine on earth?
- (73) Have you ever undergone what you believed to be a scientific or medical examination by an “extraterrestrial” being?

PSYCHOTIC EXPERIENCES (15)

- (2) Have you ever found that the familiar boundaries between people, events, time and space were blurred or not as accessible as they once were?
- (11) Have you ever experienced distressing voices inside your head that didn't seem to belong to you?
- (13) Have you ever experienced a time when your sentences were unclear or didn't make sense?
- (17) Have you ever feel strange and cut off from the world with everything moving in slow motion?
- (26) Have you ever been really convinced of something being real even though others did not share the same belief?
- (34) Have you ever found yourself desperately trying to make sense of an unfamiliar environment?
- (40) Have you ever experienced someone outside of yourself controlling your body or actions?
- (43) Have you ever heard voices as distinct from your own coming from inside your head?
- (49) Have you ever experienced significant difficulties in keeping up with social and/or occupational obligations?
- (54) Have you ever believed that your thoughts were being interfered with in some way?
- (77) Have you ever felt that your "internal world" was being played out in the external communication of those around you?
- (80) Have you ever found your everyday thoughts becoming confused or not joining up properly?
- (87) Have you ever experienced seeing, hearing, feeling, smelling or tasting something that no one else could?
- (95) Have you ever experienced great difficulty in organising your thoughts?
- (107) Have you ever found yourself laughing inappropriately or becoming angry or upset without a reason?

LIE SCALE (9)

- (4) If you say you will do something, do you always keep your promise no matter how inconvenient it might be to do so?
- (9) Once in a while do you lose your temper and get angry?
- (15) Do you occasionally have thoughts and ideas that you would not like other people to know about?
- (23) Are all your habits good and desirable ones?
- (27) Do you sometimes gossip?
- (33) Would you always declare *everything* at customs, even if you knew that you could never be found out?
- (42) Have you ever been late for an appointment or work?
- (47) Of all the people you know, are there some whom you definitely do not like?
- (53) Do you sometimes talk about things you know little about?