

Spiritual Emergence or Psychosis?

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Some of the signs and behavioral symptoms that the DSMIII-R (American Psychiatric Association, 1987) classifies under schizophrenia appear in individuals who may be experiencing a nonordinary state of consciousness that is not indicative of mental disease. It is, rather, a potentially transformative state that can, with proper treatment, lead the individual through the crisis into a higher state of being. Christina and Stanislov Grof (1986) maintain that “these experiences — spiritual emergencies or transpersonal crises — can result in emotional and psychosomatic healing, creative problem-solving, personality transformation, and consciousness evolution.”

Although these states have historical and multi-cultural precedents, our society has no categories for these experiences and the people undergoing them, and the similarities to the symptoms of psychosis lead the authorities to treat what might be considered a mystical state as pathology. The DSMIII-R does acknowledge the difficulty of distinguishing the “beliefs or experiences of members of religious or other cultural groups” from delusions and hallucinations and cautions us not to consider them evidence of psychosis when shared and accepted by a cultural group. This might cover mystical experiences that occur under the auspices of a particular sect or within a cultural context, but it does not address the variety of states that might be considered spiritual emergencies or mystical experiences.

The Grofs have grouped the spiritual crises they have seen personally and reviewed in written accounts into six categories, which I will summarize here.

1. Awakening of Kundalini (Serpent Power)

Kundalini is an energy described by Indian scholars as residing at the base of the spine. When aroused, it can rise through the chakras (psychic centers situated along the spine from the tailbone to the top of the head), creating physical symptoms ranging from sensations of heat and tremors to involuntary laughing or crying, talking in tongues, nausea, diarrhea or constipation, rigidity or limpness, and animal-like movements and sounds.

Kundalini does not rise only in those who know about it and actively seek to arouse it. A variety of spiritual practices can bring it on, and it has been known to occur in people who have done nothing consciously to awaken it. A discussion of this spontaneous awakening can be found in Sanella (1978).

Kundalini awakening can resemble many disorders, medical as well as psychiatric. The physical nature of the symptoms can bring to mind conversion disorder, and it might also lead to a misdiagnosis of epilepsy, lower back problems, incipient multiple sclerosis, heart attack or pelvic inflammatory syndrome. The emotional reaction to the awakening of Kundalini can be confused with disorders involving anxiety, depression, aggression, confusion and guilt.

Unlike those suffering from psychosis, individuals experiencing Kundalini rising are “typically much more objective about their condition, communicate and cooperate well, show interest in sharing their experiences with open-minded people, and seldom act out” (Grof, 1986).

2. Shamanic Journey

Shamanism occurs in various forms in many cultures all around the globe, and the preparation for the shaman usually involves an experience of a nonordinary state of

consciousness that provides an encounter with death and rebirth. This can take the form of a dream or vision of descent into the underworld where torture and annihilation take place, followed by rebirth and return to the upper realms. Within the appropriate cultural context, this journey is often a resolution for an illness that had been diagnosed as a shamanic or initiatory illness, and the shaman returns from the journey not only healed, but able to heal others.

The Grofs note that the psychiatric interpretation of the behavior of the shaman relates it to hysteria, schizophrenia or epilepsy. In actuality, shamanistic cultures “clearly differentiate between a shaman and a person who is sick or insane” rather than attributing shamanism to any bizarre experience or behavior they do not understand.

Nevertheless, certain characteristics of the shamanic experience parallel those of the prepsychotic (Pelletier & Garfield, 1976).

“ . . . hypersensitivity prior to the shamanistic experience, powerful emotional reactions to personal traumas and/or impasses, feelings of inadequacy, and difficulties in relating to others approximate, if not duplicate, the symptoms of the prepsychotic.”

Silverman (1967, cited in Pelletier & Garfield, 1976) claims that the behavior and cognition of both the schizophrenic and the shaman are a result of a particular ordering of psychological events. He sees the essential difference between the two states as a matter of the psychosocial environments that exist around them. The emotional supports and mode of working with the shamanic illness found in a shamanic culture are generally unavailable to the schizophrenic in our culture, and this leads to an entirely different outcome. The cognitive reorganization that takes place in each is patterned by the expectations of the culture, so that although the original state is similar, the end state is not.

3. Psychological Renewal Through Activation of the Central Archetype

This category is based on the ideas of J. W. Perry (1974, 1986), a psychiatrist who has worked with psychotic patients in ways that support a transformation involving “emotional healing, psychological renewal, and deep transformation of the patients’ personalities” (Grof 1986, p.11). When this transformative process was not suppressed with the standard anti-psychotic drugs, Perry found patterns that express what he calls the central archetype. This involves a theme not unlike the shamanistic death and rebirth, but on a larger scale. Here the cycle is a world cycle, and the individual often experiences him/herself as holding a central position in a global or cosmic conflict. For women, this can take the form of giving birth to a savior, while for men the experience is more likely to be their own birth as messiah or other world leader.

The spiritual crisis here resembles ritual dramas of renewal that have existed in one form or another for five thousand years (Perry, 1986, p. 35) From this standpoint, the prepsychotic condition of the individual is considered the psychopathology, while the psychotic episode is a process of healing and transformation.

4. Psychic Opening

The DSMIII-R regards belief in parapsychological phenomena as part of the criteria for schizophrenia, but there has been enough scientific research yielding positive results (Targ & Harary, 1984) to warrant at least an open mind. Psychic opening is a state in which an individual experiences a large number of occurrences that can be considered paranormal. These might include clairvoyance (visions of past, future or remote events) out-of-the-body experiences, telepathy, or poltergeist phenomena. Synchronistic events are often a feature of this type of transpersonal crisis, occurring in a way that defies statistical probabilities.

5. Emergence of Karmic Pattern

This crisis is marked by the experience of reliving events that appear to take place in another time period and usually in another place. The individual experiences these sequences as memories from a previous incarnation, and often sees various emotional, psychosomatic and interpersonal problems in his or her present life in a new perspective. Biological birthing is often relived in combination with the past life experience and a curious pattern has emerged linking the two. For example, strangulation by the umbilical cord is often associated with memories involving hanging or strangling in a past life. Scenes of suffering in dungeons, torture chambers and concentration camps correspond to experiencing the first stage of labor, involving contractions within the uterus.

Many individuals caught up in the experience of a past life scenario see this as bizarre and insane, as our culture does not present any concept that might explain it. These visions can continue for months or years, causing distortions in interpersonal relations as well as a variety of emotions and physical sensations. These experiences can be dramatically therapeutic when integrated, alleviating emotional, psychosomatic and interpersonal problems of long standing. Regardless of the origin or true cause of these sequences, they can be utilized by an individual to understand his or her own current life more fully.

As for understanding the true basis for this phenomenon, there are no definitive answers. Certainly the belief in reincarnation is widespread in other cultures. In addition, interesting corroborative information has been obtained by following up on the few experiences that have provided enough specific clues to allow for that. There are other possible explanations for this, so we have no proof of reincarnation, even if we can find proof that an individual's past life experience provides historically correct information that they could not have known otherwise.

6. Possession States

The Grofs describe this crisis as the emergence of an archetype of evil that is identified as demonic by the possessed individual. They say that this type of possession state "can underlie serious psychopathology such as suicidal depression, murderous aggression, impulses for antisocial behavior, or craving for excessive doses of alcohol and drugs. They imply that there might be some relationship to multiple personalities as well.

The Grofs describe therapy hours that resemble medieval exorcisms when the archetype appears during the session. Often there is choking, projectile vomiting, or frantic motor behavior with temporary loss of control. To resolve the problem, the archetypal pattern must be allowed to emerge and exteriorize, leading to a liberating and therapeutic experience. The Grofs do not go

into detail about what type of support is required from the therapist in this situation beyond the need to be “not afraid of the uncanny nature of the experiences involved.”

In addition to the demonic sort of possession state that the Grofs describe, I would imagine that more benevolent possession states would also fit in this category. There are many cultures where the deliberate induction of possession states is part of a valued religious experience. This includes Haitian voodoo ceremonies where specific deities are invited to ‘ride’ the bodies of the worshippers during specific ceremonies (Metraux, 1959, p. 121), as well as the dancers of Bali who become the entity they are portraying in ritual drama. Even in our country there exist religious groups who consider it desirable to be possessed by the Holy Spirit, with physical manifestations that include shaking and speaking in tongues (Sargant, 1975). P. Buckley (1981) cites E. Bourguignon as concluding that possession trance is an ability that is part of the human potential, as his worldwide studies show that it is utilized in a large percentage of societies.

Not covered in these six categories is the classical mystical experience that is understood as a union with the divine. Much of the historical written literature describing mystical experiences falls into this category and comparisons have been made of these accounts with those of psychotics. Buckley gives an example comparing St. Augustine’s mystical experience with the description John Cusance wrote of his psychotic experience (Buckley, 1981). These descriptions demonstrate beautifully the similarity (at least in the retrospective description) between the two experiential states. It would be difficult to distinguish between them on the basis of the 200-300 words of description that Buckley excerpted.

Buckley delineates several specific concepts often found in descriptions of both mystical and psychotic experiences.

1. Feeling of being transported beyond the self to a new realm
2. Feeling of communion with the ‘divine’
3. Sense of ecstasy and exultation
4. Heightened state of awareness
5. Loss of self-object boundaries
6. Powerful sense of noesis
7. Distortion of time-sense, particularly time-distortion
8. Perceptual changes
 - A. Synesthesia
 - B. Dampening or heightening
9. Hallucinations

The hallucinations found in mystical experiences are more often of the visual than the auditory type. A frequently described vision for both states is “the sensation of seeing and being enveloped in ‘light’” (Buckley, 1981).

The heightened state of awareness can also be understood as a “lowering of perceptual thresholds that allows greater awareness of alternate states or of inner life” (Zinberg, 1977, cited in Oxman, Stanley, Rosenberg, Schnurr, Tucker, and Gala, 1988). Buckley refers also to a breakdown in the ‘stimulus barrier.’ This characteristic, as well as many of the others mentioned by Buckley, is shared by hallucinogenic drug states. In all three states there is also an increase in primary process thinking.

Oxman, et al conducted a computerized content analysis of written passages describing schizophrenia, hallucinogenic drug experiences and mystical experiences with autobiographical accounts as controls. According to their findings, “schizophrenic subjects emphasize illness/deviance themes; hallucinogenic accounts emphasize altered sensory experience; mystical accounts focus on religious/spiritual issues; and normal control subjects emphasize adaptive and interpersonal themes.”

Although this study produced data showing that individuals experiencing these distinct states use certain categories of words more frequently, I am not convinced that the authors’ conclusions follow. They say, for instance, that the schizophrenics associated their experience with “a sense of impairment, inner badness, and illness” based on the fact that words from the Deviation and Medical categories appeared with higher frequency. The examples that they used to illustrate this seem to point more to the way those around the schizophrenics responded to and labeled the experience than to an intrinsic sense within the individual. The authors feel that their findings imply a clear dissimilarity among altered states, but what I understand from the information they offered is that the retrospective descriptions of altered states reflect the attitudes prevalent in the cultures that surround the individuals experiencing them.

There are differences between schizophrenic and mystical experiences other than those put forth by Oxman, et al. One major difference is that disruption of thought is not seen in most mystical states. Disturbances in language and speech and flatness of affect are also not characteristic of this state. Apart from possession states, self-destructive acts and aggressive and sexual outbursts are not seen in mystical experiences either. In addition, the mystical state is self-limited and generally brief.

Rama, Ballentine and Ajaya (1976, p. 198) contend that what distinguishes the seemingly similar euphoric psychotic states and what they refer to as the experience of higher consciousness is the fragmented nature of the psychotic experience. The euphoria may abruptly reverse itself and become a horrific vision of the psychotic as a sinner in hell. The mystic is able to integrate the sometimes contradictory inner world from an expanded consciousness, unlike the psychotic, who is at the mercy of his/her disordered thinking processes.

Wilber (1980, p. 156) views the schizophrenic break at its best as a regression in the service of the ego that can leave the individual with a healthier ego, despite the fact that the experience was not sought after and happens against his or her will. The mystic, on the other hand, while exploring the same realms as the schizophrenic, is mastering those realms rather than being overwhelmed by them.

“The mystic seeks progressive evolution. He trains for it. It takes most of a lifetime - with luck - to reach permanent, mature, transcendent and unity structures. At the same time, he maintains potential access to ego, logic, membership, syntax, etc. He follows a carefully mapped out path under close supervision. He is not contacting past and infantile experiences, but present and prior depths of reality.”

As this quote suggests, there is a difference between the individual who consciously embarks on a journey of what Wilber refers to as a progressive evolution and the schizophrenic who experiences a break without prior preparation. This difference does not totally account for some of the varieties of mystical experience that the Grofs describe (spontaneous Kundalini awakening, for example), nor does it deal with the fact that for some the schizophrenic experience can be a transformative healing process while for others it is not.

One study (Rappaport, Hopkins, Hall, Belleza & Silverman, 1978) found that for some patients anti-psychotic medication is not the treatment of choice if the goal of treatment is long-term clinical improvement rather than immediate symptom reduction. The authors argue that “the stormy phase of schizophrenia can be looked upon as an attempt at reorientation, at solving problems of living.” Anti-psychotic medications that reduce neurological sensitivity may interfere with the individual’s reintegrative responses, decreasing problem-solving ability, sensory and psychological sensitivity, and ability to learn. It also makes it physiologically nearly impossible for a psychotic to maintain whatever stimulus attenuation maneuvers he/she has developed to provide a ‘safe space’ in which to problem-solve.

The need for ‘retreat’ or ‘safe asylum’ is emphasized by Perry, as well (1986). He points out that in the high state of arousal of the individual experiencing a psychotic break, the mundane world’s activities can feel painful and confusing. The individual needs to have the freedom to experience the mythic world he/she is dwelling in. This can be facilitated by an environment of supportive people willing to be with an individual exhibiting bizarre behavior. Perry has set up a facility staffed by people who know “the difference between a meaningful inner process and pathology, not through hearsay or because of a liberal intellectual view, but as a result of actual experience” (Perry, 1986). Rather than medicating the symptoms, a therapeutic environment is created to offer support to the renewal process that is unfolding in the individual in crisis.

The question becomes one of deciding who is appropriate for the type of treatment that is being suggested here. Rappaport, et al found that young males at the onset of a first or second acute schizophrenic episode with good rather than poor premorbid histories and with time-limited paranoid characteristics at the onset of their break were the most likely to benefit from non-medication treatment. The study did not include females and chronic or other subgroups of schizophrenics, so no comments could be made about these groups in this paper.

I am making an assumption here that the schizophrenics in the Rappaport, et al study are of the same type as those that Perry works with and that Buckley was quoting from in his examples of psychotic experiences that bear some resemblance to mystical states. Certainly the treatment procedures employed by Rappaport, et al and Perry are similar. Both advocate a

treatment milieu with a supportive staff able to tolerate bizarre behavior and to understand the acute schizophrenic episode as “a period in which there is an opportunity to reintegrate and to return to a better personal and interpersonal level of functioning” (Rappaport, et al).

It seems that the issue for the therapist faced with a client who appears to be experiencing a psychotic break is more involved than whether or not this could be a mystical experience that is being interpreted as ‘craziness’ due to our lack of cultural acceptance for nonordinary states of consciousness. Even if it appears to be a psychotic break there is the question of whether this individual could grow and evolve from this experience into a healthier and more integrated person with the appropriate treatment. Unfortunately, there are few facilities that approach schizophrenia with this attitude, and mistreated, this individual might miss the chance for a transformative experience and find him/herself stuck.

Wilber (1984a,b) has created a system for understanding the cause and treatment of mental disorders, ranging from those we are most familiar with (psychoses, narcissistic-borderline disorders, psychoneuroses) to disorders that occur further along the spectrum of consciousness development. He agrees that at the psychotic level physiological or pharmacological intervention is the appropriate treatment. However, he points out that further up the evolutionary pathway of consciousness, psychic pathology can resemble psychosis. At this point of development, the recommended treatment is Jungian therapy involving some structure building.

Wilber sees psychopathological possibilities at every level of psychic development, and suggests appropriate treatment for each. The Grofs, while acknowledging the logic behind Wilber’s classification system, contend that the clinical realities are not so pure and clear-cut. They recommend a basic trusting relationship with the client as a foundation for mediating a new understanding of the process the client is undergoing. If the therapist can convey respect for the healing and transforming nature of the crisis and support the process, its positive potential can be utilized.

The Grofs have developed a therapeutic technique involving hyperventilation, music and sound technology and body work that they use to assist individuals in transpersonal crises. They suggest the use of artistic and expressive therapy techniques such as drawing, psychodrama, dance, and sandplay. Of course, when the crisis is so intense as to prevent the individual’s functioning in the world, there is the difficulty of finding a facility that is willing to work with alternatives to the medical model. There are actually three 24-hour facilities in the U.S., two of which are in California, that are knowledgeable about and willing to work with spiritual emergencies, and hopefully this number will grow in years to come.

There is a growing amount of information available about transpersonal crises, what they are and how to treat them. There is also a growing number of therapists with the expertise and experience to treat them. The Spiritual Emergency Network, an information and referral network for transpersonal crises, has been in existence in Menlo Park for several years now. It is my hope that these are indications of a growing sophistication in the field of psychology that will allow for a deeper understanding of nonordinary states of consciousness than the DSMIII-R’s categories allow for. We have, as human beings, barely scratched the surface of our capabilities and potentials, and as we explore further we will surely find much that does not fit our current

understanding of the mind and body and how they work. If we can maintain open minds, there is much we can learn.

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