SPIRITUAL CRISIS OR PSYCHOPATHOLOGY?

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Current psychological theory and practice does not make a distinction between psychopathology and crises of personal transformation, called spiritual crisis or spiritual emergency. If these states of spiritual crisis are treated in a supportive manner rather than suppressed by psychotropic drugs, spiritual crises can be healing and beneficial to the person who experiences them. It would be useful for mental health professionals to have a standard method of distinguishing between psychopathology and spiritual crisis in clinical practice. The purpose of this study is to determine what criteria therapists are using in their clinical practice to distinguish between these two states.

Data were obtained from a sample of fifteen transpersonally-oriented therapists currently in clinical practice. Telephone interviews were undertaken with each therapist in which the respondents were asked how they make the distinction between psychopathology and spiritual emergency in their clinical practice.

The three most frequent responses the therapists stated they used in making the distinction were whether the client was a danger to self or others, how the client was able to function in their daily life, and whether the client had a history of mental illness.
All therapists but one utilized some criteria in their clinical practice for making a distinction between psychopathology and spiritual crisis. The average number of criteria utilized was 3.5 and much of the criteria utilized was in accordance with the published literature. Most therapists in this study did not appear, however, to utilize all the available published criteria in making the distinction between psychopathology and spiritual crisis.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. THE PROBLEM</td>
<td>Introduction</td>
</tr>
<tr>
<td></td>
<td>Background of the Problem</td>
</tr>
<tr>
<td></td>
<td>Purpose of the Study</td>
</tr>
<tr>
<td></td>
<td>The Research Question</td>
</tr>
<tr>
<td></td>
<td>Significance of the Study</td>
</tr>
<tr>
<td></td>
<td>Definition of Terms</td>
</tr>
<tr>
<td></td>
<td>Assumptions and Limitations of the Study</td>
</tr>
<tr>
<td></td>
<td>Organization of the Remainder of the Study</td>
</tr>
<tr>
<td>2. LITERATURE REVIEW</td>
<td>Introduction</td>
</tr>
<tr>
<td></td>
<td>Growth Model of Mental Illness</td>
</tr>
<tr>
<td></td>
<td>The Medical Model</td>
</tr>
<tr>
<td></td>
<td>The New Paradigm</td>
</tr>
<tr>
<td></td>
<td>Transpersonal Psychology</td>
</tr>
<tr>
<td></td>
<td>Spiritual Emergence and Spiritual Emergency</td>
</tr>
<tr>
<td></td>
<td>Forms of Spiritual Emergency</td>
</tr>
<tr>
<td></td>
<td>The Relationship between Spiritual Emergency and Psychopathology</td>
</tr>
<tr>
<td></td>
<td>Methods of Making a Distinction between Spiritual Emergency and Psychopathology</td>
</tr>
<tr>
<td>3. METHODOLOGY</td>
<td>Purpose</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>TABLE</td>
<td>Title</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>TABLE I</td>
<td>DIFFERENCES BETWEEN SPIRITUAL EMERGENCE AND SPIRITUAL EMERGENCY</td>
</tr>
<tr>
<td>TABLE II</td>
<td>SYMPTOMS: SPIRITUAL EMERGENCY VERSUS PSYCHOPATHOLOGY</td>
</tr>
<tr>
<td>TABLE III</td>
<td>DIFFERENTIATION BETWEEN SPIRITUAL EMERGENCY AND PSYCHIATRIC DISORDERS</td>
</tr>
<tr>
<td>TABLE IV</td>
<td>PSYCHOSIS OR SPIRITUAL EMERGENCY?</td>
</tr>
<tr>
<td>TABLE V</td>
<td>LISTING OF INTERVIEW SUBJECTS, BY DATE OF INTERVIEW</td>
</tr>
<tr>
<td>TABLE VI</td>
<td>MATRIX OF INTERVIEW RESPONSES</td>
</tr>
</tbody>
</table>
CHAPTER 1
THE PROBLEM

Introduction

Dramatic experiences and unusual states of mind are usually diagnosed by traditional psychology as mental disorders. Some of these experiences may actually be crises of personal transformation, and can be called spiritual crises, spiritual emergencies, or mental illness with growth potential (Grof & Grof, 1989). These types of episodes have been described in sacred literature of all ages as results of meditative practices and signposts of the mystical path (Grof & Grof, 1989). When these states of mind are properly understood and treated in a supportive manner rather than suppressed by standard psychological treatment, they can be healing and beneficial to the person who experiences them. "Spiritual emergencies have a positive potential and should not be confused with diseases that have a biological cause and necessitate medical treatment" (Grof & Grof, 1989, p. x).

Background of the Problem

Current psychiatric theory and practice, as reflected in the manual for classifications of psychopathology, the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994b), does not make a
distinction between psychopathology and spiritual crisis. The medical model is the theoretical framework supporting the field of psychiatry. The medical model views symptoms and disorders for which there is no etiology as psychiatric disorders (Miller, 1990).

Current psychiatric practice dictates that a diagnosis must be established for each client seen. These diagnoses can be unreliable and stigmatizing (Miller, 1990).

There is a lack of professional consensus about many issues in the field of mental health, perhaps more than in any other profession. Disagreement exists in the mental health field about how and why psychopathology develops, what mental illness is, and which therapeutic approaches are effective (Miller, 1990).

The medical model is based on a materialistic view that holds that only the physical world known through sensory experience and organized by rational thought is real. Anything not accessed through these channels either does not exist or is not important. (Fahlberg, Wolfer, & Fahlberg, 1992). Under this model, development is largely determined by biological and social processes that move through normal stages from infancy to early adulthood defined primarily in physical and behavioristic terms. "If all goes well, the end product is a well-adjusted adult with a strong ego and skills for being a productive, respected, and secure member of society" (Fahlberg, et al., 1992, p. 46).

Another view of human development, called transpersonal psychology,
has been suggested by some theorists and researchers (Bragdon, 1993; Grof & Grof, 1989; Grof & Grof, 1990; Perry, 1989; Wilber, 1986). This view recognizes other realms of reality in addition to the physical-material, methods of knowing which cannot be explained by physical reality (Fahlberg, et al., 1992). New theories and levels of human experience have been mapped which go beyond the well-adjusted ego into a transpersonal spiritual identity.

One such theory involves a transpersonal identity, in which there "is a process of moving beyond a sole identity with the self...to experience a sense of unity with other human beings and the universe" (Fahlberg, et al., 1992, p. 47). This emergence from a self-identity to a transpersonal one can be upsetting because one may lose one's sense of consensual reality. This may result in a spiritual crisis, with symptoms ranging from emotional distress to psychopathology (Fahlberg, et al., 1992).

Those in the field of psychiatry, however, tend to believe that "mysticism of any kind is a primary process and/or a primarily defensive adjustment pattern that individuals may use to resolve personal problems" (Miller, 1990, p. 32). These were the findings of a study of 300 psychiatrists by the Group for the Advancement of Psychiatry (1977).

Because the medical model tends to pathologize all unusual states of mind and experiences, these spiritual crises may be mistaken by the psychiatric community as psychopathology. These spiritual crises, if treated supportively and not pathologized, may result in profound personal transformation (Fahlberg,
The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) and current psychiatric practice does not make a distinction between spiritual crisis and psychopathology. In addition, there is a lack of training of mental health professionals in distinguishing between the two (Bragdon, 1993).

Purpose of the Study

It would be useful for mental health professionals to have a standard method of distinguishing between psychopathology and spiritual crises that have growth potential so that proper treatment for each can be facilitated. It is the purpose of this study to determine what criteria, if any, therapists are currently using to distinguish between spiritual crisis and psychopathology, which may be used to establish such a standard method.

The Research Question

The research question is: what criteria are selected therapists using in their clinical practices to distinguish between spiritual crisis and psychopathology?

Significance of the Study

It would be useful for mental health practitioners in general to have a
standard method of distinguishing between psychopathology and spiritual crisis so that proper treatment for each can be undertaken. Results of the study could be of value in developing such a standard that can be used by mental health practitioners who wish to make this distinction in their clinical practices.

Definition of terms

Spiritual Emergence - "the process of personal awakening into a level of perceiving and functioning that is beyond normal ego functioning. It involves having spiritual experiences and integrating these experiences into a positive framework for increased well being" (Bragdon, 1993, p. 303).

Spiritual Emergency - "profound disorientation and instability that sometimes accompanies intense spiritual experience. Spiritual emergency appears as an acute psychotic episode lasting between minutes and weeks. It has a positive, transformative outcome" (Bragdon, 1993, p. 303).

Spiritual experience - "any experience of the transpersonal level of consciousness" (Bragdon, 1993, p. 303).

Spiritual crisis - in this study, "spiritual crisis" and "spiritual emergency" are used interchangeably (Miller, 1990).

Transpersonal - "having to do with experiences that are beyond normal ego states" (Bragdon, 1993, p. 303).

Spirituality - "the relationship between a person and a transcendent being or force or a higher being; it goes beyond a specific religious affiliation" (Lukoff, Turner, Lu, 1992a, p. 674).

Mystical experience - "a transient, extraordinary experience marked by feelings of unity, harmonious relationship to the divine and everything in existence, as well as euphoric feelings, noesis, loss of ego functioning, alterations in time and space perception, and the sense of lacking control over the event" (Lukoff, et al., 1992a, p. 678).

Psychopathology - psychologically abnormal, maladjusted, emotionally disturbed or mentally ill (Comer, 1992).
Therapist - mental health practitioner who holds a master's degree or higher in counseling, psychology, or a closely related field.

Psi - a general term to identify extrasensory perception and psychokinesis (Mishlove, 1983).

Extrasensory perception - "experience of, response to, state, event, or influence without sensory contact" (Mishlove, 1983, p. 4).

Psychokinesis - "direct influence exerted by the subject on an external physical process, condition, or object" (Mishlove, 1983, p.5).

Religiosity - "adherence to the beliefs and practices of an organized church or religious institution" (Lukoff, Turner, & Lu, 1992b, p. 674).

Ego states - "the executor of personality", it "must master at the various stages of development certain important biological and social tasks to facilitate the healthy adaptation of the individual to his or her life circumstances" (Monte, 1991, p. 266).

In this paper, the terms "spiritual" and "religious" are used. They have each been define previously in this chapter. For the purposes of the issues addressed in this paper, spirituality and religiosity are related in accordance with the statements of Bragdon (1993):

Is there a difference between spiritual and religious problems? Perhaps not, if we believe that all problems that emerge in relation to one's religious life are essentially spiritual in nature. However, there are specific problems which arise which have to do with one's relationship to the beliefs and practices of an organized religious institution, or conversion to a particular faith...I will call these specific problems "religious". Problems relating to spiritual experience and the transcultural experience of relationship with higher forces will be "spiritual" in nature...(p. 17)
Assumptions and Limitations of the Design

Assumptions:

(1.) It is assumed that subjects responded to interview questions accurately and honestly.

(2.) Behaviors reported are an accurate reflection of the subject's general behavior.

(3.) Due to the controversial nature of the survey, it is assumed that participants were willing to talk about the topic in a professional and honest manner.

Limitations:

(1.) Data may be biased in that they may not accurately represent all criteria used by therapists to distinguish between spiritual crisis and psychopathology.

(2.) Professional behaviors of subjects may be affected by other stimuli than those chosen to be examined in this study.

(3.) Responses of subjects may be influenced by social desirability of agreement with professional and organizational goals, such as the counseling and psychology profession, and the American Psychological Association.

(4.) These findings may not be representative of all mental health professionals because the sample was selected from professionals with a "transpersonal" orientation and because of the small sample size.

(5.) The results of the study lack predictive power.

Organization of the Remainder of the Study

Chapter Two, the Review of the Literature, will provide a theoretical review of the growth model of mental illness, a look at the medical model under which psychology currently functions, a review of the new paradigm of
transpersonal psychology, forms of spiritual emergency, and methods of making a distinction between spiritual crisis and psychopathology.

Chapter Three, The Methodology, will review the purpose of the study with a description of the methodology used. A description of the research design, the sample population and the instrumentation to be used, as well as the data collection procedures and method of data analysis will be discussed.

Chapter Four, The Presentation and Analysis of the Data, will present the findings of the survey.

Chapter Five, The Summary, Conclusions, and Recommendations, will contain an overview of the entire study with recommendations for future research.
CHAPTER 2

LITERATURE REVIEW

Introduction

This chapter will provide a theoretical review of the growth model of mental illness, a look at the medical model under which psychology currently functions, a review of the new paradigm of transpersonal psychology, forms of spiritual emergency, and methods of making a distinction between spiritual crisis and psychopathology.

Growth Model of Mental Illness

It has been noted by numerous clinicians and researchers that for some individuals undergoing psychiatric episodes, the experience may result in positive growth. (Grof & Grof, 1989; Boisen, 1962; Dabrowski, 1964; Bowers, 1973a). If these episodes are treated with love, understanding, and encouragement, the episode may resolve itself without suppressive medication (Perry, 1989). Bowers (1973a) suggests that the way the individual deals with a psychosis can determine the outcome. If this episode can be seen as a growth struggle by the one experiencing it, positive growth is a more likely outcome. Increasingly, individuals experiencing unusual or dramatic states of mind that might be labeled psychopathological, emerge from these experiences
with an increased sense of well-being and a higher level of functioning in daily life (Grof & Grof, 1989). These experiences have been labeled by some theoreticians (Grof & Grof, 1989; Bragdon, 1993; Grof & Grof, 1990; Perry, 1989; Watson, 1994) as mystical or transpersonal experiences.

Mystical experiences have several important characteristics. The root word of "mystical" come from the Greek *muestes* meaning "someone who has been initiated into secret rites" (Lukoff, 1985, p. 158). Further derivatives of this word indicate a root word that means "inarticulate sound." One of the main characteristics of the mystical experience has been its ineffability; the mystical experience defies expression by words (Lukoff, 1985).

Another important characteristic of the mystical experience is that it has the ability to change the individual's life. For example, among some suicidal individuals, experiences of a mystical nature seemed to lessen suicidal impulses (Lukoff, 1985).

Spiritual literature and traditions throughout the world validate the healing power of these extraordinary states. This view can be found in the concepts and practices of the Buddhist, Hindu, Christian, Sufi, and other mystical traditions (Grof & Grof, 1989).

Cultures throughout history have developed techniques to precipitate these experiences for healing purposes. For example, in shamanic cultures, psychospiritual crises are interpreted as an indication that an individual's destiny is to become a shaman (a healer or spiritual leader) rather than as a sign of

There has always existed a connection between madness and mystical states. "Both are experiences that begin with a nonordinary state of consciousness, where discursive, analytic thinking has lost its dominance...the universal significance of both these states is in the attempt to advance beyond the existing conditioned personality" (Podvall, 1979, p. 571).

Individuals experiencing a psychosis can confirm the elusive relationship between insanity and mysticism. "The psychotic inner world often explodes with a state of ecstasy, feelings of profound truth, contact with ultimate reality, and excruciating insights into the nature of self" (Podvall, 1979, p. 572). These experiences are also characteristic of the life-changing qualities of the mystical experience.

In a study of first-hand accounts of religious experiences, the following experiences were noted (Lukoff, 1985, p.159):

- Visions (18%)
- Voices (7%)
- Telepathy (4%)
- Contact with the dead (8%)
- Sense of certainty, enlightenment (19%)
- Exaltation, ecstasy (5%)
- Sense of purpose behind events (11%)

Many of these symptoms would be described as psychopathology by the psychiatric profession.
Studies on subjective accounts of individuals in psychotic episodes compared with more "normal" altered states have shown that these states have in common "heightened consciousness or awareness" (Buckley, p. 517). Buckley goes on to say "loss of self-object boundaries, a frequent accompaniment of acute psychosis, is often seen in the classic mystical experience" (p. 518).

Podvall (1979) believes there is an elusive relationship between insanity and mysticism. The schizophrenic illness can function as an attempt at "radical transformation of the self" (p. 573). The "mystic experience within a psychosis is a most vital attempt at recovery and a direct expression of the desire to transcend and remodel an intolerable image of self and life situation" (p. 573).

These and other altered states of consciousness can be a natural human function. "The central nervous system appears to possess a latent capacity, neurobiologically speaking, for a pattern of functioning which...is human psychotic consciousness" (Bowers, 1973b, p. 214).

Podvall (1979) postulates that the potentiality for the mystical experience resides within the inherent structure of the mind and the occurrence of this state "is not necessarily a sign of deficiency or failure" (p. 573).

Other theoreticians have postulated on the healing function of these dramatic states of mind. Perry (1976) states the primary function of the psychotic episode is to enable the individual to understand the symbolic meanings in their life. He believes that if medication can be avoided, the
individual can experience the imagery coming forth from the psyche as meaningful and healing.

Jung felt that the mythological themes that appear during episodes of psychosis can be examined and interpreted as meaningful to the patient (Miller, 1990). Grof & Grof (1989) state that the "episodes of unusual states of mind, even those that are dramatic and reach psychotic proportions are not necessarily symptoms of disease in the medical sense" (p. 2). They can be viewed "as crisis of the evolution of consciousness" or 'spiritual emergencies' comparable to states described by the various mystical traditions of the world" (Grof & Grof, 1989, p. 3).

While symptoms of psychopathology and these dramatic spiritual experiences are similar, numerous distinctions have been made. It has been noted that schizophrenia differs from the mystic state in several ways (Group for the Advancement of Psychiatry, 1977). The mystic

...differs from the schizophrenic in three important ways. First, his retreat is facultative rather than obligatory; second, it is partial rather than complete, as compared to a schizophrenic's retreat; third, he finds it possible, frequently desirable, to associate with others who share his view of the world--that is, he participates in mystical fraternities, while the schizophrenic rarely is able to form or maintain similar affectionate ties with others. (p. 784)

Research attempting to determine the incidence of kundalini phenomenon in psychiatric patients (particularly psychotic patients) has shown that the kundalini syndrome (a form of spiritual emergency) is not common in these patients (Greyson, 1993).
The Medical Model

Mainstream psychiatry has generally embraced the medical model (Miller, 1990). The medical model in turn reflects mainstream scientific thinking and worldview. This view, assumed by much of Western society, holds that reality is the physical world known through sensory experience and organized by rational thought. Anything that cannot be verified by the five senses and organized by rational thought either does not exist or is not important (Fahlberg, et al., 1992). "All acquisition of information and communication can occur only in material systems, such as the brain or the physiochemical structure of genes, and requires the exchange of currently known and measurable energies" (Grof & Grof, 1990, p. 248).

According to this model, the universe is one in which only the "tangible, material, and measurable are real, all forms of religious and mystical activities are seen as reflecting ignorance, superstition and irrationality or emotional immaturity. Direct experiences of spiritual realities are...interpreted as 'psychotic' manifestations of mental disease" (Grof & Grof, 1989, p.3)

"One of the fundamental (but rarely conscious) assumptions of psychology and Western science in general is that the universe is essentially fragmented, accidently created, and meaningless" (Frager, 1989, p. 290).

Traditional psychology assumes that human beings are mainly their bodies and are generally isolated from each other and from the environment (Frager, 1989).

Under this view, human development is defined and measured primarily
in physical and behavioristic terms. "If all goes well, the end product is a well-adjusted adult with a strong ego and skills for being a productive, respected and secure member of society" (Fahlberg et al., 1992, p. 46).

Unusual states of consciousness are seen by traditional psychiatry as pathological. The states are attributed to anatomical, physiological and biochemical changes in the brain and other medical causes (Hendlin, 1985). "All definitions of psychosis emphasize the individual's inability to discriminate between subjective experiences and the world of consensus reality, often referred to as objective reality" (Grof & Grof, 1990, p. 249). Traditionally, psychiatry approaches these states by controlling and suppressing them (Hendlin, 1985; Fahlberg et al., 1992).

Historically, the field of psychiatry tends to ignore or pathologize the spiritual realm in human beings. Freud saw religion as a "wishful illusion" or as a regressive state and characterized mysticism as "infantile helplessness" and "regression to primary narcissism" (Lukoff et al., 1992b, p. 674).

Clinical literature has portrayed the mystical experience as "symptomatic of ego regression, borderline psychosis, a psychotic episode or temporal lobe dysfunction" (Lukoff et. al, 1992b, p. 673). Deikman (1977) comments on the 1976 report on mysticism by the Group for Advancement of Psychiatry as follows, "the authors follow Freud's lead in defining the mystic perception of unity as a regression, an escape, a projection upon the world of a primitive infantile state" (p. 214).
Albert Ellis, the originator of a cognitive therapy, as described by Lukoff, et al. (1992a), views religion as equivalent to irrational thinking when he says "The elegant therapeutic solution of emotional problems is quite unreligious...The less religious they (clients) are, the more emotionally healthy they will tend to be" (p. 41-42).

The current manual for classifications of psychopathology, the DSM-IV (American Psychiatric Association, 1994b) reflects these views. The intellectual foundation for this medical classification is rooted in ideas of the 15th to 18th century. This foundation includes three major ideas:

First was the doctrine of the ontology of disease, which was basic to the development of a general, formal classification system. This viewed illnesses as naturalistic objects, each with an independent existence and its own distinctive structure and course: nameable, classifiable, explicable, and subject to systematic study. Second, beginning in the 17th century through the work of thinkers like Descartes, Boyle, and Newton, was the rise of the mechanistic philosophy and its application to medicine. This allowed bodily organs to be conceived as part structures affecting each other and the whole. Third was the identification of the brain-nervous system as a major concept in disease nomenclature, classification, and explanation. (Fabrega, 1992, p. 5)

Fabrega (1992) goes on to say that these attitudes resulted in the "secularization and materialization of illness...and the progressive authority of central nervous system structure and function, impersonal biomedical concepts, and scientific psychology, along with abandonment of lay concepts and meanings concerning madness and related conditions" (p.5).

Halling & Nill (1989) assert that the DSM-III is based on historical assumptions that mental illness is organically based. As a result, the clinician
has little reason to understand how patients experience their own behavior and how their symptoms relate to their patient's circumstances.

Lukoff, et al. (1992b) states that psychiatry assigns primacy to biology over culture. "Through its premature 'biologism', contemporary psychiatry overlooks essential knowledge about the cultural basis of behavior and organism-environment interactions" (p. 676).

Frequently, a diagnosis must be made by therapists when seeing a client. These labels can be unreliable, socially stigmatizing and related to the clinician's orientation, the client's gender, or socioeconomic status (Miller, 1990). Some argue that all diagnoses are arbitrary, dehumanizing, and disregards the uniqueness of the individual. Diagnoses tend to stick even if inaccurate (Halling & Nill, 1989).

Confusion also exists over the term "psychotic". There are two meanings, one which denotes a temporary state, and the other one which has life-long implications (Miller, 1990; Lukoff et al., 1992a). Temporary psychotic episodes (in contrast to the long-term) have been observed to result in improvement in the patient's functioning (Lukoff et al., 1992a).

The New Paradigm

Researchers and clinicians in the mental health field have found that many experiences of individuals seem to contradict Western science. Clients report experiences that transcend physical boundaries, experiences of extra-
sensory perception, near-death experiences, and other extraordinary states.

Because these experiences are not compatible with the older, materialistic

paradigm, a new paradigm has been called for by some, one that is compatible

with modern theoretical physics (Frager, 1989).

There eventually comes a time when recognition of limitations of a given

paradigm gives rise to the search for a new paradigm...anomalies are

discovered, new data that cannot be readily explained by the old

theories...the adoption of a new paradigm involves a new way of seeing.

(Frager, 1989, p. 296)

Relativity theory and related developments in physics form a new way of

conceptualizing the universe: space and time are not separate; the flow of time

depends on the position of the observer; matter is not solid at the subatomic

level (Frager, 1989). According to this new view, "the physical universe has

come to be viewed as a unified web of paradoxical, statistically determined

events in which consciousness and creative intelligence play a critical role"

(Grof & Grof, 1990, p. 249).

The realization from these developments in science that the universe is

not a mechanical system but a complex interplay of phenomena has set the

groundwork for an understanding of reality based on entirely new principles.

Grof & Grof (1990) assert that this knowledge reveals human beings as

paradoxical in nature with two complementary aspects.

In everyday situations involving ordinary states of consciousness, it might

seem appropriate to think of people as biological machines. However, in

nonordinary states of mind they can also show properties of infinite fields

of consciousness -- transcending time, space, and linear causality.

This is the image that mystical traditions have described for millennia. (p.

251)
An increasing interest in Eastern mysticism and other similar phenomenon in recent years indicates that individuals are increasingly in need of an outlook that goes beyond the materialistic, mechanistic viewpoints of Western cultures (Miller, 1990). Spirituality is an issue that is intertwined with psychological health (Vaughn, 1991).

Surveys conducted on the general public in the U.S. have consistently shown that religious beliefs and practices are very important. Gallup polls and other studies have shown that 30-40% of the population has had a "mystical experience", many the result of near-death experiences (Bragdon, 1993). In contrast, studies have shown that mental health professionals place far less importance on religion than the general public (Lukoff et al., 1992a).

Several psychological models include spirituality in their views. Abraham Maslow believed each individual has a need for spiritual and transcendent experiences (Vaughn, 1991). Roberto Assagioli, a pioneer of psychoanalysis in Italy, asserted that "spiritual drives or spiritual urges are...real, basic, and fundamental" (Chandler, Holden, & Kolander, 1992, p. 168). Jung first introduced the practice of incorporating the spiritual dimension into psychotherapy (Chandler et al, 1992; Lukoff et al., 1992a).

**Transpersonal Psychology**

One psychological approach that includes spirituality in psychology is the
"transpersonal" approach. The transpersonal psychological approach "seeks to help clients integrate the transcendental or spiritual and personal dimensions of existence, to help them fulfill their unique, creative individuality" (Wittine, 1989 p.269). Wittine (1989) explicates the basic postulates of transpersonal psychology:

(1) "Transpersonal psychotherapy is an approach to healing/growth that addresses all levels of the spectrum of identity--egoic, existential, and transpersonal" (p. 270). The ego identity is a stable, relatively constant system of "mental self-and world constructs that gives us the sense of being particular beings separate from other...beings" (p.270). The "existential self" is the next developmental step, where an individual embarks on a process of self-discovery of their true individuality. The "transpersonal identity" goes beyond either the egoic or existential. Human beings cannot be truly whole until they realize the connection with a deeper level of identity, the Self. The Self is a pure transcendent consciousness, without boundaries. It is changeless, formless, indivisible, and whole. "The Self is the essence of the entire world, of all worlds, inner and outer, and all levels of identity, high and low, above and below" (p. 274).

(2) "Transpersonal psychology recognizes the therapist's unfolding awareness of the Self and his or her spiritual world-view as central
in shaping the nature, process, and outcome of therapy" (p. 278). The therapist's consciousness, state of mind, and orientation determines their therapeutic stance.

(3) Transpersonal psychotherapy is a process of awakening from a lessor to a greater identity...As therapists, we...compassionately yet persistently help our clients identify and let go of those self-definitions and patterns of living that are impeding enhances self-awareness and emergence of a greater identity. (p. 280)

(4) "Transpersonal psychotherapy facilitates the process of awakening by enhancing inner awareness and intuition" (p. 282).

(5) "In transpersonal psychotherapy, the therapeutic relationship is a vehicle for the process of awakening in both client and therapist" (p. 283).

For transpersonal psychologists, human development is seen to have the potential to move beyond the "well-adjusted, productive adult ego" (Fahlberg et al., 1992, p. 45). These theoreticians suggest the possibility of an individual's growth into modes of consciousness that transcend the normal view of the "self" and reality (Fahlberg et al., 1992).

Transpersonal psychology, as a philosophy and method of psychotherapy is not new. It reflects both great philosophic systems that have
existed throughout history and also more contemporary psychological ideas (Miller, 1990).

There are many forms of experience of a transpersonal nature. When individuals experience transpersonal phenomenon, they often begin to perceive synchronistic events in the environment. Jung postulated these synchronistic events link the unconscious to external reality. "Cause and effect" is replaced by meaningful coincidence (Cited in Miller, 1990).

The idea of synchronicity is in accordance, some scientists agree, with recent discoveries in physics. David Bohm, a former co-worker of Einstein "described the world that we observe in our ordinary state of consciousness as representing only one partial aspect of reality. He identifies another level of reality that cannot be observed directly except possibly in nonordinary consciousness such as deep meditative and mystical states" (Cited in Miller, 1990, p. 35).

Mythological themes may emerge during transpersonal experiences. John Weir Perry, a Jungian psychiatrist who works with psychotic patients observed that many of these patients manifested standard patterns and stages that resulted in positive growth if they were not suppressed by psychotropic medicine. Observing and working with these patients, Perry found that the patterns and themes experiences by these individuals have appeared in the mythologies of cultures throughout history. (Miller, 1990).

The relevance of myth to psychosis was explicated further by Joseph
Campbell, one of the world's leading experts on comparative mythology. He wrote about a pattern seen in mythology called the "hero's journey", which is characterized by stages that Campbell saw as metaphors for the venture into the psyche. Campbell states "to my amazement...the imagery of schizophrenic fantasy perfectly matches that of the mythological hero's journey" (cited in Miller, 1990, p. 38).

Bragdon (1993) suggests other spiritual experiences that include the awakening of expanded perceptual abilities such as:

- **precognition**: the ability to see into the future through awake vision or dream.

- **clairvoyance**: the ability to perceive constellations energy through inner sight which are imperceptible to ordinary vision.

- **clairsentience**: the ability to feel energies in one's own body which duplicate the emotions, physical wellness, or thoughts of another being.

- **clairaudience**: the ability to hear messages from a source of intelligence which goes beyond the rational information of the present life.

- **healing**: the ability to manifest healthgiving changes in the physiology or psychology of oneself or another through laying on of hands, prayer, or psychic transmission.

- **psychokinesis**: the ability to move material objects through psychic transmission (p. 11-12.)

**Spiritual Emergence and Spiritual Emergency**

Bragdon (1993) defines "spiritual emergence" as "the process of creating
a meaningful context to integrate spiritual experiences" including "re-evaluating conceptual frameworks for what is real and what is meaningful in life" (p. 17).

Grof & Grof (1990) state that spiritual emergence is a natural function of human beings and defines it 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" (p. 34).

When spiritual emergence is rapid and dramatic, this natural process can become a crisis. These growth experiences may overwhelm the individual, challenging their belief system and threatening their experience of consensual reality. When this occurs, spiritual emergence becomes spiritual emergency.

Spiritual emergencies can occur spontaneously or can be triggered by emotional stress, physical exertion, disease, accident, etc. (Hendlin, 1989; Watson, 1994). Many cultures and ethnic groups have developed techniques for precipitating these crises for healing purposes (Hendlin, 1989).

A spiritual crisis can include a wide spectrum of experiences: intense emotions, visions, unusual thought processes and various physical symptoms (Grof & Grof, 1989). In a crisis situation, one may be overwhelmed by tumultuous inner experiences that challenge one's relationship to consensual reality. (Watson, 1994).

Bragdon (1993) states that the natural process of spiritual emergence may turn into a spiritual emergency when:
(1) The individual experiencing the process has no conceptual framework to support the experience, or to understand and accept the phenomenon.

(2) The individual has neither the physical or emotional flexibility to integrate the experience into their life.

(3) The family, friends, or helping professionals of the individual see the phenomenon in terms of psychopathology which have no possibility of being positive.

Table I, pg. 26-27 delineates the differences between spiritual emergence and spiritual emergency.

In the context of the developmental model previously presented, spiritual emergencies can be viewed as "catalysts for and expressions of developmental change rather than as pathological symptoms of mental illness (Fahlberg et al., 1992, p. 45). These crises have positive potential for personal growth and healing and need to be differentiated from psychopathology and from organic disease (Watson, 1994; Grof & Grof, 1989).

**Forms of Spiritual Emergency**

The manifestations of spiritual emergency are highly individual and will not fall into distinct diagnostic categories that can be easily distinguished from each other (Grof & Grof, 1989).

Grof & Grof (1990) state that, in general, ten types of spiritual emergencies can be identified:
<table>
<thead>
<tr>
<th>Emergence</th>
<th>Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inner experiences are fluid, mild, easy to integrate.</td>
<td>Inner experiences are dynamic, jarring, difficult to integrate.</td>
</tr>
<tr>
<td>New spiritual insights are welcome, desirable, expansive.</td>
<td>New spiritual insights may be philosophically challenging and threatening.</td>
</tr>
<tr>
<td>Gradual infusion of ideas and insights into life.</td>
<td>Overwhelming influx of experiences and insights.</td>
</tr>
<tr>
<td>Experiences of energy that are contained and are easily manageable.</td>
<td>Experiences of jolting tremors, shaking energy disruptive to daily life.</td>
</tr>
<tr>
<td>Easy differentiation between internal and external experiences and transition from one to other.</td>
<td>Sometimes difficult to distinguish between internal and external experiences, or simultaneous occurrence of both.</td>
</tr>
<tr>
<td>Ease in incorporating nonordinary states of consciousness into daily life.</td>
<td>Inner experiences interrupt and disturb daily life.</td>
</tr>
<tr>
<td>Slow, gradual change in awareness of self and world.</td>
<td>Abrupt, rapid shift in perception of self and world.</td>
</tr>
<tr>
<td>Excitement about inner experiences as they arise, willingness and ability to cooperate with them.</td>
<td>Ambivalence toward inner experiences, but willingness and ability to cooperate with them using guidance.</td>
</tr>
<tr>
<td>Accepting attitude toward change.</td>
<td>Resistance to change.</td>
</tr>
<tr>
<td>Ease in giving up control.</td>
<td>Need to be in control.</td>
</tr>
<tr>
<td>Emergence</td>
<td>Emergency</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Trust in process.</td>
<td>Dislike, mistrust of the process.</td>
</tr>
<tr>
<td>Difficult experiences treated as opportunities for change.</td>
<td>Difficult experiences are overwhelming, often unwelcome.</td>
</tr>
<tr>
<td>Positive experiences accepted as gifts.</td>
<td>Positive experiences are difficult to accept, seem undeserved, can be painful.</td>
</tr>
<tr>
<td>Infrequent need to discuss experiences.</td>
<td>Frequent urgent need to discuss experiences.</td>
</tr>
<tr>
<td>Discriminating when communicating about process (when, how, with whom).</td>
<td>Indiscriminate communication about process (when, how, with whom).</td>
</tr>
</tbody>
</table>

(1) **Episodes of Unitive Consciousness.**

An individual...feels a sense of overcoming the usual divisions...of the body and mind and reaching a state of complete inner unity and wholeness...and experiences a state of ecstatic union with humanity, nature, the cosmos, and God...have a sense of leaving ordinary reality...and entering a timeless, mythical realm. (p. 75)

These experiences can become a source of spiritual crisis because of a lack of understanding in Western culture about nonordinary states of consciousness.

(2) **The Awakening of the Kundalini.** Ancient Indian literature describes this phenomenon. The experience is attributed to the awakening of a form of subtle energy called the Kundalini that, according to the Indian tradition, creates and sustains the cosmos. The awakening of the normally dormant energy can bring into consciousness memories of psychological and physical traumas, birth traumas, and other dramatic experiences. Individuals experiencing the Kundalini phenomenon have intense sensations of energy and heat streaming up their spines, and their bodies are often overcome by violent shaking and spasms. The individual can be unexpectedly overtaken by powerful emotions and can experience fear of death, loss of control and impending insanity.

(3) **Near-Death Experiences.** Individuals who come close to death may have dramatic experiences in which they relive their life in an
incredibly condensed form, consciousness can detach from the body, experiences such as radiant light beyond human imagination that many describe as God are reported where the individual is taught profound lessons about life and universal laws. Many people who have had these experiences come back to life with a deep determination to live in accordance with the experiences they had in their near-death experience.

(4) **Emergence of "Past-Life Memories".** Individuals may experience sequences that took place in other historical period or places. These experiences are usually emotionally charged and portray astonishing details. Individuals frequently report the conviction that these events are personal memories from previous lifetimes.

(5) **Psychological Renewal Through Return to the Center.**

People involved in the renewal process experience dramatic sequences that involve enormous energies and occur on a scale that makes these individuals feel they are at the center of events that have global or even cosmic relevance. Their psyche becomes a fantastic battlefield where the forces of Good and Evil are engaged in a universal combat that seems critical to the future of the world. (p. 86)

(6) **The Shamanic Crisis.**

This form of psychospiritual transformation bears a deep
resemblance to the initiatory crises of shamans--healers and spiritual leaders of many aboriginal peoples... Visionary adventures... typically involve a journey into the underworld--the realm of the dead. There, one is attacked by vicious demonic entities and exposed to unimaginable ordeals culminating in experiences of death, dismemberment, and annihilation... The final annihilation can be experiences as being killed, torn to pieces, or swallowed by specific animal who functions as initiators. The same animals may appear later in the roles of spirit guides, protectors, and teachers. This experience of total annihilation is typically followed by resurrection, rebirth, and ascent to celestial realms. (p. 89)

(7)

Awakening of Extrasensory Perception (Psychic Opening).

Includes an increase in intuitive abilities including out-of-body experiences. Telepathy or tuning deeply into the inner processes of others is another form of this phenomenon. Precognition, or the awareness of events in the future can also occur.

(8)

Communicating with Spirit Guides and Channeling. The individual comes into contact with an entity that appears to be entirely separate from one's own identity or inner process. They usually appear to be discarnate human beings, suprahuman entities or deities; entities inhabiting higher planes of consciousness and endowed with extraordinary wisdom. Channeling has played an important role in history. Many spiritual teachings are derived from scriptures of channeled material, including the Indian Vedas, the Koran, and the Book of Mormon.
Psychologists C. G. Jung and Roberto Assagioli credit some writings to channeled material. In some instances, the experience of channeling can be intrusive and seriously interfere with everyday life.

**Experiences of Close Encounters with UFOs.** Often people who claim to have encountered UFO's feel they have been initiated into transpersonal states because the beings they have encountered seem to exist at higher stages of consciousness than their own. These encounters can precipitate serious emotional crises that have much in common with spiritual emergencies.

**Possession States.** The individual experiencing this phenomenon has a sense that one's body and psyche have been invaded and are being controlled by an alien entity that has personal characteristics. This entity is perceived as coming from the outside and not belonging to one's personality. This phenomenon on the surface is associated with severe types of psychopathology. However, Grof claims that is the individual is given the opportunity to confront and express the disturbing energy in a supportive setting, profound healing can take place.
The Relationship Between Spiritual Emergency and Psychopathology

Psychiatry, in its diagnostic classification systems, theory, research, and practice tends to ignore or pathologize spiritual experiences. (Lukoff, et al., 1992b). Lukoff et al. (1992b) have noted that all twelve references to religion in the glossary of the DSM-III (American Psychiatric Association, 1980) are used to illustrate psychopathology. A report on mysticism by the Group for the Advancement of Psychiatry (1977) tends to associate spiritual experience with psychopathology. Psychiatric literature has described mystical experiences as symptomatic of ego regression, borderline psychosis, and psychotic episodes (Lukoff et al, 1992b).

Traditional psychiatry does not make a distinction between mystical or spiritual experiences with growth potential and those which indicate a mental disorder (Lukoff et al., 1992b; Miller (1990); Hendlin (1985); Lukoff et al., 1992a). Because traditional psychiatry does not make the distinction between mystical and psychotic experiences, mental health professionals have not been trained to diagnose and treat patients experiencing spiritual emergencies. If these experiences can be understood as the manifestation of a difficult stage in a natural developmental process, spiritual emergencies can result in healing and personal transformation. (Hendlin, 1985; Lukoff et al., 1992b).

In a survey of members of the American Psychiatric Association, 83% of the respondents reported that religion was not an issue in any training and only 50% felt competent to address spiritual concerns in therapy (Lukoff et al.,
The DSM-III-R not only lacks a specific category for mental disorders with a growth potential, it does not mention the possibility of psychotic episodes with positive outcomes (Lukoff et al., 1992a). Lukoff et al., (1992b) have proposed a new category for the DSM-IV defined as "psychospiritual problems":

Psychospiritual problems are experiences that a person finds troubling or distressing and that involve that person's relationship with a transcendent being or force. These problems are not necessarily related to the beliefs and practices of an organized church or religious institution. Examples include near-death experiences and mystical experiences...This category can be used when the focus of treatment or diagnosis is a psychoreligious or psychospiritual problem that is not attributable to a mental disorder. (p. 44)

According to Lukoff et al., (1992b) this new code would help with the treatment of religious and spiritual issues by increasing the accuracy of diagnostic assessments when spiritual and religious issues are involved, would reduce the incidence of misdiagnosis of psychoreligious and psychoreligious problems, help improve treatment of these problems by encouraging clinical research, and encourage the training of mental health professionals in the areas of the religious and spiritual dimensions of the human experience.

The DSM-IV (American Psychiatric Association, 1994a) does include a category for "Other Conditions That May Be a Focus of Clinical Attention" called "Religious or Spiritual Problems". The description of this category is:

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 spiritual values that may not necessarily be related to an organized church or religious institution. (p.
Some phenomenon of spiritual emergency have been misconstrued as signs of pathology. Bragdon (1993) lists some of the criteria of psychosis according to the DSM-III-R that can also be found in spiritual emergency:

1. A disorientation which makes a person less interested in work, in social contacts and in self-care.
2. A difficulty in communicating about one's experience to others (in spiritual emergency this is the result of the noetic quality of the experience, not symptomatic of confused thinking).
3. Dissociation (in spiritual emergency this dissociation is a transitory part of the process of integrating one's experience). (p. 39)

Bragdon (1993) furthers notes that these phenomenon subside after a spiritual emergency while in chronic psychosis they do not.

Bragdon (1993) notes that the 1987 edition of the DSM-III-R names the symptoms of psychosis to include the following:

1. Delusions.
2. Hallucinations.
3. Incoherence or loosening of associations.
4. Markedly illogical thinking.
5. Behavior that is grossly disorganized or catatonic (p.84).

Bragdon (1993) comments that "these criteria did not differentiate the delusions and hallucinations of the psychotic from the visions and psi phenomena of spiritual experience" or "the 'word salad' characteristic of the psychotic from the jumbled speech of someone trying to articulate the noetic quality of a spiritual experience" or "the disorganized behavior of the psychotic and the bizarre behavior of a kundalini experience" (p. 84). One of the problems of differentiating spiritual emergency and psychopathology is that
there are many similarities in the symptoms. See Table II (p. 36-37) for a list of these symptoms.

Although spiritual experiences can be pathologized, pathology can also be spiritualized. Individuals experiencing genuine mental disorders or psychosis can be mistaken for individuals undergoing a spiritual emergency. (Fahlberg et al., 1992). Ken Wilber, a major transpersonal psychological theoretician, addresses this issue in his writings about the need to discriminate between "transpersonal phenomenon that reflects an immature level of ego organization and these same phenomenon which reflect a manifestation of mature psychospiritual development" (Waldman, 1992, p. 137).

Methods of Making a Distinction between Spiritual Emergency and Psychopathology

Several theoreticians and clinicians (Grof & Grof, 1990; Hendlin, 1985; Sannella, 1992) have written about how clinicians can make the distinction between psychopathology and spiritual emergency in clinical practice. A medical and psychiatric examination should be performed to rule out brain dysfunction and other diseases for individuals purporting to experience a spiritual emergency (Hendlin, 1985). Grof & Grof (1990), as shown on Table III (p. 38-40), put forward the comparative criteria they formulated for differentiating spiritual emergency and psychiatric disorder. Grof & Grof explain that the purpose of this differentiating criteria is to determine the treatment
TABLE II

Symptoms - Spiritual Emergency vs. Psychopathology

<table>
<thead>
<tr>
<th>FORMS OF SPIRITUAL EMERGENCY</th>
<th>SIMILAR CRITERIA FOR MENTAL DISORDERS IN DSM-III-R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Streaming energy, tremors, sensations of heat/cold, spasms and violent shaking, involuntary laughing/crying, unusual breathing patterns, and/or visions of light.</td>
<td>Hyperactivity associated with manic syndrome.</td>
</tr>
<tr>
<td></td>
<td>Alteration in physical function.</td>
</tr>
<tr>
<td></td>
<td>Symptom not under voluntary control &amp; psychological factors judged etiologically evolved-associated with conversion disorder.</td>
</tr>
<tr>
<td>2. Shamanic Journey:</td>
<td>Recurrent thought of death. Loss of interest or pleasure in ritual activities associated with depression.</td>
</tr>
<tr>
<td>Dreams/visions/sensing-evoking a special connection to animals and nature.</td>
<td>Somatic, grandiose, religious, nihilistic or other delusion without persecutory or jealous content associated with psychotic disorders.</td>
</tr>
<tr>
<td>Core psychic experiences=death and rebirth.</td>
<td></td>
</tr>
<tr>
<td>Preoccupation with death, rebirth, and/or return to the beginnings of life.</td>
<td>Hallucinations associated with psychotic disorders.</td>
</tr>
<tr>
<td>Focus on a clash of opposites and dramatic resolution of this opposition.</td>
<td>Recurrent thoughts of death associated with depression.</td>
</tr>
<tr>
<td><strong>TABLE II, con’t.</strong></td>
<td></td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td><strong>FORMS OF SPIRITUAL EMERGENCY</strong></td>
<td><strong>SIMILAR CRITERIA FOR MENTAL DISORDERS IN DSM-III-R</strong></td>
</tr>
<tr>
<td>(4) Psychic Opening:</td>
<td>Delusions. Hallucinations associated with psychotic disorders.</td>
</tr>
<tr>
<td>Experiences of extrasensory perception, including out-of-body experiences.</td>
<td></td>
</tr>
<tr>
<td>Experiencing dramatic sequences which seem to be occurring in a different temporal-spatial context.</td>
<td></td>
</tr>
<tr>
<td>Behavior, energetic, or emotional expression may involuntarily take on character and/or habits of another entity. Somatic consequences may include disease, addiction, or severe mental disturbance.</td>
<td>Symptom not under voluntary control. Loss of alteration in physical functioning associated with conversion disorder. Behavior that is grossly disorganized associated with psychosis. Hyperactivity associated with manic syndrome.</td>
</tr>
</tbody>
</table>

### TABLE III

**DIFFERENTIATION BETWEEN SPIRITUAL EMERGENCY AND PSYCHIATRIC DISORDERS**

<table>
<thead>
<tr>
<th>Characteristics of the process indicating need for medical approach to the problem</th>
<th>Characteristics of the process suggesting that the strategy for Spiritual Emergency might work</th>
</tr>
</thead>
</table>

#### Criteria of a Medical Nature

- **Clinical examination and laboratory tests detect a physical disease that causes psychological changes.**
- Negative results of clinical examinations and laboratory tests for a physical disease.

- **Clinical examination and laboratory tests detect a disease process of the brain that causes psychological changes.**
- Negative results of clinical examinations and laboratory tests for pathological process afflicting the brain.

- **Specific psychological tests indicate organic impairment of the brain.**
- Negative results of psychological tests for organic impairment.

- **Impairment of intellect and memory, clouded consciousness, problems with basic orientation (name, time, place), poor coordination.**
- Intellect and memory qualitatively changed but intact, consciousness usually clear, good basic orientation, coordination not seriously impaired.

- **Confusion, disorganization, and defective intellectual functioning interfere with communication and cooperation.**
- Ability to communicate and cooperate (occasional deep involvement in the inner process might be a problem.)
Characteristics of the process indicating need for medical approach to the problem

Characteristics of the process suggesting that the strategy for Spiritual Emergency might work

Criteria of a Psychological Nature

Personal history shows serious difficulties in interpersonal relationships since childhood, inability to make friends and have intimate sexual relationships, poor social adjustment, usually long history of psychiatric problems.

Poorly organized and defined content of the process, unqualified changes of emotions and behavior, unspecific disorganization of psychological functions, lack of meaning of any kind, no indication of direction or development, loosening of associations, incoherence.

Autistic withdrawal, aggressivity, or controlling and manipulative behavior interferes with a good working relationship and makes cooperation impossible.

Adequate pre-episode functioning as evidences by interpersonal skills, some success in school and vocation, network of friends, and ability to have sexual relationships; no serious psychiatric history.

Sequences of biographical memories, themes of birth and death, transpersonal experiences, possible insight that the process is healing or spiritual in nature, change and development of themes, often definable progression, incidence of true synchronicities (evident to others)

Ability to relate and cooperate, often even during episodes of dramatic experiences that occur spontaneously or in the course of psychotherapeutic work.
TABLE III, con't.

**Criteria of a Psychological Nature, con't.**

<table>
<thead>
<tr>
<th>Characteristics of the process indicating need for medical approach to the problem</th>
<th>Characteristics of the process suggesting that the strategy for Spiritual Emergency might work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inability to see the process as an intrapsychic affair, confusion between the inner experiences and the outer world, excessive use of projection and blaming, &quot;acting out.&quot;</td>
<td>Awareness of the intrapsychic nature of the process, satisfactory ability to distinguish between the inner and the outer, &quot;owning&quot; the process, ability to keep it internalized.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Basic mistrust, perception of the world and all people as hostile, delusions of persecution, acoustic hallucinations of enemies (voices) with a very unpleasant content.</th>
<th>Sufficient trust to accept help and cooperate; persecutory delusions and voices absent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violations of basic rules of therapy (&quot;not to hurt oneself or anybody else, not to destroy property&quot;), destructive and self-destructive impulses and a tendency to act on them without warning.</td>
<td>Ability to honor basic rules of therapy, absence of destructive or self-destructive ideas and tendencies, or ability to talk about them and to accept precautionary measures.</td>
</tr>
<tr>
<td>Behavior endangering health and causing serious concerns (refusal to eat or drink for prolonged periods of time, neglect of basic hygienic rules)</td>
<td>Good cooperation in things related to physical health, basic maintenance, and hygienic rules.</td>
</tr>
</tbody>
</table>

strategy for the client. If the clinician concludes they are dealing with a spiritual emergency, practically they are concluding the client would benefit from special treatment strategies for treating spiritual emergencies.

Table IV, pg. 42, delineates methods for distinguishing between brief reactive psychosis and spiritual emergency. According to Bragdon (1993), the symptoms of brief reactive psychosis and spiritual emergency are most often confused.

Sannella (1992) explicates several criteria for differentiating between psychosis and the kundalini awakening. He states that clinicians often have a sense for the "smell" of psychosis that tells if the client is "unbalanced or whether he or she is instead inundated with more positive psychic forces" (p. 110). Clients who are dangerous to themselves or others would also indicate mental illness. Those who are experiencing kundalini phenomenon are usually more objective about themselves and have an interest in sharing their experiences. Those experiencing psychosis tend to be "oblique, secretive, and totally preoccupied with ruminations about some vague but apparently significant subjective aspect of their experience that they can never quite communicate" (p. 110.) Other distinguishing features include sensations of heat common in kundalini states but rare in psychosis. When voices are heard, they are perceived as coming from within and not from outside oneself.

Grof & Grof (1990) summarize "The content of a typical spiritual emergency is a combination of transpersonal, perinatal, and biographical
<table>
<thead>
<tr>
<th>TABLE IV</th>
<th>PSYCHOSIS OR SPIRITUAL EMERGENCY?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BRIEF REACTIVE PSYCHOSIS</strong></td>
<td><strong>SPIRITUAL EMERGENCY</strong></td>
</tr>
<tr>
<td>Psychotic symptoms appear immediately following a recognizable psycho-social stressor.</td>
<td>Phenomena usually follow a recognizable psycho-social stressor; good pre-episode functioning.</td>
</tr>
<tr>
<td>Emotional turmoil and at least one of the following:</td>
<td>All of the following:</td>
</tr>
<tr>
<td>1. Incoherence or loosening of association.</td>
<td>1. Ecstatic mood.</td>
</tr>
<tr>
<td>2. Delusions.</td>
<td>2. Sense of newly gained knowledge.</td>
</tr>
<tr>
<td>3. Hallucinations.</td>
<td>3. Perceptual alterations.</td>
</tr>
<tr>
<td>4. Behavior that is grossly disorganized or catatonic.</td>
<td>4. Delusions have themes related to mythology.</td>
</tr>
<tr>
<td>5. No conceptual disorganization.</td>
<td>5. No conceptual disorganization.</td>
</tr>
<tr>
<td>6. Positive, exploratory attitude toward the experience as meaningful.</td>
<td>6. Positive, exploratory attitude toward the experience as meaningful.</td>
</tr>
<tr>
<td>7. Capacity to form and maintain an adequate working relationship.</td>
<td>7. Capacity to form and maintain an adequate working relationship.</td>
</tr>
<tr>
<td>Symptoms last more than a few hours, but less than 2 weeks.</td>
<td>Symptoms last minutes, and up to months; acute onset during 3 months or less.</td>
</tr>
<tr>
<td>An eventual return to the premorbid level of functioning.</td>
<td>Functioning enhanced after most intense period is complete.</td>
</tr>
<tr>
<td>No period of increasing psychopathology preceding the psycho-social stressor.</td>
<td>No period of increasing psychopathology preceding the psycho-social stressor.</td>
</tr>
<tr>
<td>Disturbance is not due to any other mental disorder or organic disorder.</td>
<td>Disturbance is not due to any other mental disorder or organic disorder.</td>
</tr>
</tbody>
</table>

experiences. It shows a reasonable degree of coherence... and likely revolves around" the themes of spiritual emergency presented earlier in the chapter.

They go on to say:

Among the favorable signs are a history of reasonable psychological, sexual, and social adjustment preceding the episode, the ability to consider the possibility that the process might originate in one's own psyche, enough trust to cooperate, and a willingness to honor the basic rules of treatment. Conversely, a lifelong history of serious psychological difficulties and of marginal sexual and social adjustment can generally be seen as suggesting caution...a confused and poorly organized content of the experiences...primary symptoms of schizophrenia...manic elements, the systematic use of projection, and the presence of persecutory voices an delusions indicate that traditional approaches might be preferable. Strong destructive and self-destructive tendencies...are further negative indicators. (p. 256)

This literature review covered the growth model of mental illness, including a description and history of the mystical experience. Literature explicating the similarities between mental illness and spiritual experiences was reviewed. The medical model was reviewed, as well as the theoretical underpinnings for the current methods of classifications of psychopathology. A new paradigm that has been suggested by researchers which takes into consideration new developments in science and physics was reviewed. Writings about transpersonal psychology, a psychological approach that includes the spiritual realms of the human being and is in accordance with these new scientific discoveries, are examined. Finally, literature on the distinction between spiritual emergency and psychopathology and forms of spiritual emergency was considered.
Purpose

It would be useful for mental health practitioners to have a standard method of distinguishing between psychopathology and spiritual crises that have growth potential so that proper treatment for each can be facilitated. It is the purpose of this descriptive study to determine what criteria therapists are using to make this distinction in clinical practice.

Identification of the methodology

The descriptive method of research was utilized for this study. The descriptive method is characterized by ease of use and it produces data that is accurate and representative. This method allows the researcher to study the phenomenon that is the subject of the research as it actually happens in real-life clinical situations (Merriam & Simpson, 1984). The exploratory nature of the descriptive method is appropriate for the subject under investigation.

Description of the methodology

A survey in the form of an interview was utilized. The interview technique allows the exploration of this complex topic and allows greater depth
than other techniques (Merriam & Simpson, 1984). The format used for this study was an unstructured interview, which was recorded. The interviews were conducted over the phone.

Sample

A sample of 15 transpersonally-oriented therapists were utilized. The selection was made by three methods. The first method of selection was by therapist referral. Various therapists were asked to refer the researcher to transpersonally-oriented therapists in town. The second method was to select subjects from the 1994 List of Professional Membership of the Association for Transpersonal Psychology. The third method was personal referral. The researcher personally knew of several transpersonally-oriented therapists that were selected for interviews.

Instrumentation

The questions asked were: (a) Have you had clients in your clinical practice who have undergone experiences of spiritual emergency such as kundalini awakening, emergence of past-life memories, shamanic crisis, awakening of extra-sensory perception, communicating with spirit guides and channeling, possession state, or encounters with UFO's?; and, (b) How did you identify these experiences as a spiritual emergency and how did you differentiate them from psychopathology? Follow-up questions deemed
appropriate to the situation were asked. Table V, pg. 47, lists the interview subjects by date of interview.

A pilot test was administered to two therapists to test the face validity of the interview questions. The subjects of the pilot test were also utilized as interview subjects.

The pilot tests were administered as follows. The subjects were asked the interview questions and responded. After the subjects had responded to the interview questions, they were asked if these questions were appropriate to elicit answers to the research questions. The result of the pilot test was that one subject stated the questions appeared appropriate for the research purpose and the other subject stated the questions were appropriate as long as the population was transpersonally-oriented. Based on the results of the pilot test, the researcher concluded the questions were appropriate to the answer the research question for the population of interest.
TABLE V
LISTING OF INTERVIEW SUBJECTS BY DATE OF INTERVIEW

<table>
<thead>
<tr>
<th>#</th>
<th>DATE OF INTERVIEW</th>
<th>PROFESSIONAL DEGREE (Note A)</th>
<th>PROFESSIONAL CERTIFICATION (Note B)</th>
<th>YEARS OF PROFESSIONAL PRACTICE</th>
<th>PRACTICE ORIENTATION</th>
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<td>1</td>
<td>9/10/94</td>
<td>M.C.</td>
<td>C.P.C.</td>
<td>15</td>
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<td>M.S.W.</td>
<td>C.I.S.W.</td>
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<td>Combines transpersonal and traditional</td>
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<td>C.P.C.</td>
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<td>Clinical Psychologist</td>
<td>20</td>
<td>Transpersonal, Gestalt, Jungian dreamwork</td>
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Note A: M.C. is Master's Degree in Counseling
M.S.W. is Master Degree in Social Work

Note B: C.P.C. is Certified Professional Counselor
C.I.S.W. is Certified Independent Social Worker
The answers to question #1: "Have you had clients in your clinical practice who have undergone experiences of spiritual emergency such as kundalini awakening, emergence of past-life memories, shamanic crisis, awakening of extra-sensory perception, communicating with spirit guides and channeling, possession states, or encounters with UFO's?" were as follows:
(The therapists interviewed are referred to as "T" in this chapter.)

T #1: Yes.

T #2: Yes.

T #3: Yes.

T #4: "I have had someone I would describe as having had a spiritual emergency; this would be along the lines of opening of extra-sensory awareness." In general, she doesn't have many clients with a spiritual emergency because "it's a new paradigm and most clients stay hidden and get medicated". She states there is nothing to say that a client who is schizophrenic may also be having a spiritual emergency -- there can be a combination of factors involved with any client. The therapist looks at the issue the client brings in and works with that rather than worrying about how to label
T #5: "I would put the experience I have had as more of an awakening of higher sense perception."

T #6: "I have had clients who have had energy moving through their bodies -- I'm hesitant to say what is is when a person has an experience of energy. I've had clients who have felt alot of energy in their bodies. I teach Yoga so I'm hesitant to say that the energy moving through their bodies is a Kundalini awakening."

T #7: Yes.

T #8: Yes.

T #9: "That's not just what I call spiritual emergency. That's your definition. Everyone who comes to see me has a spiritual emergency. I do not see such a dichotomous point of view. That there's ordinary psychopathology that is due to genetic proclivity; or due to a biochemical interaction...I believe it is impossible to separate the nature of one's reality from one's spiritual awareness. Everyone who comes to see me from my perspective has a spiritual crisis. I define spirit as that ineffable force within that propels us forward. That aspect of the human spirit that allows us to deal with whatever we face."

T #10: Some specific ones I've had experience with -- yes.

T #11: Yes.

T #12: "All but the last one."
T #13: Yes.

T #14: Yes.

T #15: She had very few clients with these symptoms. Her experience has been more with clients who have had spiritual experiences such as psychic experiences or through active imagination or recalling a past life. "When people have come up with spiritual experiences, they haven't been experiences that put them off-center. They've been more of experiences that expanded their awareness; they didn't initiate a crisis." She prefers to use the term "spiritual awakening" rather than spiritual emergency.

In response to question #2: "How did you identify these experiences as a spiritual emergency and how did you differentiate them from psychopathology?, the following responses were elicited. Table VI, p. 51 summarizes the responses to question #2.

T #1 doesn't think in terms of psychopathology; she states that is not her orientation. She uses psychopathological terminology for filing insurance claims but doesn't take the labels seriously. When asked if she sees a spiritual emergency as being a forms of psychopathology she says no. There is a genetic component to some forms of psychopathology such as schizophrenia, for example. She states it is easier to work with a relatively healthy population at a spiritual level because they are not functioning at a survival level. Severe psychopathology would mean a person functions at a survival level; she is dealing with an infant. These individual should not be introduced to an form of
<table>
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<tr>
<th>RANKED BY FREQ CRITERIA NAMED</th>
<th>CRITERIA NAMED</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
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<th>#6</th>
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<th>#11</th>
<th>#12</th>
<th>#13</th>
<th>#14</th>
<th>#15</th>
<th>TOTAL # OF RESPONSES</th>
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<tr>
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<td>Client is a danger to self or others</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
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<td>2</td>
<td>Client's ability to function in their daily life</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>2</td>
<td>History of psychosis or other mental illness; prior psychiatric hospitalizations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>3</td>
<td>Can client separate spiritual experience from ordinary reality?</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
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<td>Client has ego strength</td>
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<tr>
<td>4</td>
<td>Therapist's &quot;gut-level&quot; reaction or intuition.</td>
<td>X</td>
<td></td>
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<td>X</td>
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<td>4</td>
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<tr>
<td>5</td>
<td>Is client &quot;grounded&quot;?</td>
<td>X</td>
<td></td>
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<td>X</td>
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<td>X</td>
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<tr>
<td>6</td>
<td>Quality of client life and relationships; ability to establish relationship with therapist</td>
<td>X</td>
<td></td>
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<td>X</td>
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<tr>
<td>6</td>
<td>Is client using spiritual experience to avoid personal issues?</td>
<td>X</td>
<td></td>
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<tr>
<td>6</td>
<td>Therapist looks for reason client would make up spiritual emergency</td>
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<td>X</td>
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<td>Client experiencing high levels of panic, anxiety, or fear</td>
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<td>Therapist looks for patterns in client's life; is there other pathology?</td>
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<td>Is client acting in ethical way?</td>
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<td>Fragmentation in client's thinking</td>
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<td>7</td>
<td>Is client curious or surprised about spiritual experience?</td>
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<tr>
<td>7</td>
<td>Therapist looks at specific themes occuring in spiritual experience</td>
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<td>Family history of psychiatric illness</td>
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"spiritual opening-up" because there is not enough ego.

T #2 says the distinction is very tricky, especially with manic-depressives who sound and think they're having a spiritual emergency but they are really losing touch with the ability to function. In general, her distinctions are as follows:

1. Is the client able to function in their daily life. This is her major criterion in terms of deciding whether to continue supportive counseling or sending them for medication.

2. She looks at whether the client is a danger to self or others.

3. She determines what their spiritual framework is -- if the client is not spiritually-oriented and won't listen to possible spiritual interpretations of what's happening -- she will not work with them from a spiritual perspective. The client may choose to see themselves as sick.

T #3 makes the distinction as follows:

1. She goes down the list of symptoms the client presents and sees if any match psychopathological symptoms. She states that often the client is bringing in a combination of psychopathological symptoms and spiritual crisis.

2. She pays attention to her gut-level feeling about her clients, what the therapist called a "visceral hit." This might alert her as to whether there is a spiritual issue going on with the client.
(3) If the client wants to hurt themselves, she would have them hospitalized. She would continue to treat the client as having a spiritual emergency even though the client is hospitalized. In her experience, if she works this way, the client often comes out of the crisis with more clarity.

(4) In her practice, she doesn't see seriously mentally ill. She would probably view seriously mentally ill as having a lifetime spiritual emergency. The seriously mentally ill individual cannot "bring themselves back."

T #4 makes the distinction as follows:

(1) She looks at whether their life is "reasonably put-together" prior to the incident. That is, the client did not have long-standing history of being psychotic, had not had previous psychotic episodes. The therapist did report a client who had had a previous psychotic episode, before coming to see this therapist. When the therapist told the client she thought the previous episode might have been a spiritual emergency, the client was "enormously relieved." The therapist thought that when the client's episode had been labelled "psychotic", the real issue of the client were put on a "back burner." In contrast, when the episode was labelled a "spiritual emergency," the client seemed better able to face issue and make important life changes. The client seemed to give herself
permission to look at values that weren't really hers and let them go and make life-changes.

(2) Therapist looks at the quality of life and the quality of relationships in the life of her client. She also looks at the ability of the client to establish a relationship with the therapist.

(3) The therapist pays attention to the "hairs on my arm" or the intuition the therapist has about the client.

T #5 makes the distinction as follows:

(1) Has there been a psychotic episode in the past or recurring psychotic episodes? But the therapist might also question whether psychotic episodes in the past might have been a spiritual emergency.

(2) How open is the client to the experience they are having -- do they become fearful or shut-down?

(3) The therapist assesses whether the client has the potential to hurt self or others.

(4) She looks at the family history of mental illness.

T #6 makes the distinction as follows:

(1) The client is "not grounded in an awareness of their own psyche" - she would call this psychopathology. If the client was not feeling grounded; if they didn't have a sense that this experience might be something important to go through; if there was not enough ego
development so they could recognize that the pain might have a spiritual dimension, there might be psychopathology involved.

(2) The therapist has a "gut-feeling" that the client is not "grounded."

(3) The rest of the client's life is not working and the client has allot of "ego involvement", that is, the client thought they were special and somewhat superior because they were going through this experience.

(4) Client has history of drug dependency or mental illness.

(5) The therapist thinks the client is using the spiritual experience to avoid personal issues.

(6) The therapist looks at how the client functions in their daily life; do they have a job, etc. This is her major criteria for making the distinction.

T #7 makes the distinction as follows:

(1) She looks at their psychiatric history. Do they have a chronic history of pathology?

(2) Ego strength development: how do they deal with reality, boundary issues in relationships and with their body. She would assess this as follows: Does the client consider their thoughts their own or someone else's? Does the clients thoughts get mixed up with someone else's thoughts?

(3) How is the client functioning in everyday life -- how grounded are
they?

(4) She assesses whether or not the client is delusional, based on their history and on how they describe the experience. Has the experience happened before? What are the client's feelings about this experience? Do they have support in their family and with friends that supports these kinds of experiences?

(5) The therapist's "gut-feeling" about whether this is a spiritual emergency or psychopathology.

T #8 makes the distinction as follows:

(1) Other than the spiritual emergency, there is nothing else occurring in the client's life that is indicative of psychopathology. Also, there is no discernable reason the client would make this up.

(2) The therapist looks at patterns in the client's life -- is there other pathology going on?

(3) The manner in which the client talks about the spiritual emergency is important; the client talks about it in a clear way and doesn't embellish it.

(4) The therapist would look at past history of psychopathology.

(5) The therapist would look at other areas of the client's life. Does the client have any other kind of crisis going on? Has the client has any recent injuries, especially to their head? Is the client in some sort of major transition? Have they recently had a
humiliating or embarrassing situation in their life? The therapist would attempt to find out what in their life is surrounding this event. He is trying to find out if the traumatic event has caused the individual to "make up" the spiritual emergency to compensate for the traumatic event.

(5) The therapist believes the content of the spiritual emergency reported is important. He would look at the content of the spiritual emergency in context to the client's life and if it looks like the spiritual emergency is in response to trauma in the client's life, he would likely not see it as a spiritual emergency. He cites the following example:

"If a client loses their job and the next week their wife divorces them and then the client tells you he's been abducted by a UFO because he was deemed the greatest human specimen, I would have doubts about this being a spiritual emergency."

(6) In general he states, "a person who is schizophrenic and having auditory hallucinations looks very different from a person who is not schizophrenic and having auditory hallucinations."

T #9 states the following:

(1) "It depends on how congruent it (the spiritual emergency) was with the rest of their (the client's) life."

(2) Whether or not he person is destructive to self or others.
(3) Whether or not the person is acting in an ethical way.

(4) Is the client "laying a trip" on the therapist? For example, if the client said "I am Jesus Christ...and I need to do something to you or you won't be saved and you'll die...that is different...they're laying a trip on me that suggests my salvation is predicated on my agreement with their perception."

(5) The therapist would see fragmentation in the client. There would be incongruence and incontinuity. Their thinking would show signs of fragmentation and disorientation -- not "ego-syntonic."

Evidence of fragmentation would be dissociation, flight of ideas, evidence of disorder thinking.

T #10 says the following:

(1) The client couldn't separate the spiritual emergency from the rest of reality. The client should know this is a spiritual kind of experience; the client knows there is a distinction between the normal way of perceiving things (consensual reality) and this experience. The client can be scared or emotional about the experience, but would know the spiritual emergency is a "separate kind of reality." The spiritual emergency doesn't spill over into consensual reality. The client has "clear boundaries" between the two. A psychotic would not know the difference between reality and the spiritual emergency.
(2) If the client has their "feet planted in reality" this is not psychopathology.

(3) The therapists views how the client describes the experience as important. If the client is curious and surprised about the experience, the therapist would be more likely to view this as a spiritual experience.

(4) "Good ego strengths" which she describes as the ego being intact and strong. This could be described as an "internal locus of control" -- the clients knows what they feel. "They kind of have a gauge inside about what's real and what's not." If these attributes are present in the client, she would tend to think pathology was not involved.

(5) How is the client functioning in their life? Can they have a spiritual experience and still function in their job, etc. If the experience doesn't spill over and affect them at work, in their relationships, etc., the therapist would not see pathology.

(6) If the client knows the spiritual emergency is something that is valuable to work with but doesn't confuse is with reality, pathology is probably not involved.

T #11 states the following, "each case has unique details. I don't use just one set of guideline." In general:

(1) The therapist looks at prior history of psychosis or multiple
personality disorder, or any hospitalization that indicates psychiatric disorders. Any of these could indicate to her that the client either has had a lengthy ongoing spiritual emergency that has been tapped into and keeps reemerging, or the client has evidence of psychopathology.

(2) She looks as the difference in "tone" of the symptoms. For example, a client is experiencing delusions (which she states is a common feature of various types of spiritual emergency). She would look for themes such as death and rebirth, a sense of being expanded into greater awareness in contrast to the individual personality awareness, prenatal experiences, etc. She also looks for the tone of experience that seems to be increasing the client's level of compassion for humanity and compassion for self, forgiveness of other people, awareness of suffering of humanity. She looks for experiences that produce a "higher level of functioning" -- which is the main thing she looks for in clients with delusions. She looks at whether the delusions are paranoid or antisocial, whether the client wants to hurt self or others. If the "delusion is helping them open into greater compassion or greater insight, I think this may be a spiritual emergency."

(3) A psychotic "cannot come out of the experience" while an individual experiencing a spiritual emergency can.
T #12 is always asking herself, for any client she sees, "is this a spiritual problem or is it a behavioral problem". She views spiritual emergency as being manifested in psychopathology symptoms. She states she always works from a spiritual perspective.

T #13 makes the distinction as follows:

1. The therapist assesses whether the client is "grounded" and in touch with reality. By grounded she means "they are congruent; whether their voice and words and their body language all say the same thing"; whether they "feel centered in their body."

2. The client is able to see the spiritual emergency as an aspect of who they are but this doesn't overwhelm them or take them over.

3. "The difference between a psychotic and an artist is that an artist can turn it off and on."

T #14 says that if a client is in distress to the point of wanting to hurt themselves (suicidal) or something or someone else, that's the point she delineates a psychological problem that "needs to be treated traditionally or in another way other than from the point of view of allowing the energies that are coming through them to be spiritual." "If there is a life-threatening or dangerous situation, I take measures to keep them (client) safe. If not, I assume it's part of a spiritual process."

T #15 says she sees pathology in a client when:

1. The client can't follow through on daily commitments;
(2) There are high levels of anxiety or panic and the therapist can't talk the client through it;

(3) The client is self-destructive.

In making the distinction, she further states the following:

(1) she assesses whether or not the client has a strong ego definition;

(2) Can the client separate themselves from the voices they're hearing;

(3) In dreamwork or trance work, can the client stay conscious with an ego base as they're relating to these contents;

(4) Can the client develop an awareness of the spiritual emergency and process the contents of it;

(5) Does the client have good ego development. That is, do they have boundaries so they can understand that the spiritual emergency is real, that it has significance, but the client can still come back to consciousness and relate to outer reality and their own thoughts and feeling state.

In response to the questions, several therapists made comments on their personal and clinical view of spirituality in relationship to their therapeutic work. Some commented on their view of psychopathologic labels. Some also commented about the nature of the questions.

Therapist #1 stated her view that a spiritual crisis is one that is caused by a person's relationship to their soul or spirit and is related to whatever is
unhealed or incomplete in them.

T #5 stated she believes spirituality is a fundamental way of looking at people. She views all clients from a spiritual perspective. She states that she would not use DSM-III-R labels if she didn't have to for insurance purposes or for diagnosis in agency work. These labels, she says provide consistency but are not all that useful. "Labels are an excuse for stopping treatment."

T #6 believes that all pain experienced by her clients "have a spiritual dimension."

T #9 does not separate the spiritual realm from ordinary reality. "Everyone who comes to see me has a spiritual crisis." He does not think the spirit can be in crisis without the mind/body involvement, so he is at odds with the term "spiritual emergency." "This is a useless dichotomy from my perspective."

T #12 states that "whenever I meet a new client, I'm concerned about the condition of their soul." She views a spiritual emergency as being manifested in psychopathological symptoms, rather than as separate phenomenon.

T #13 states she has had a lot of experience with altered states, mainly through supervised experimentation with LSD and also through meditation. She has been "anti-DSM III categories forever" but also honors "types of states people get into but don't know how to get out of."

T #14 says she assumes every issue that shows up in her clientele is a
"wake-up call" or a spiritual issue. She starts from this premise because that is how she prefers to view the human experience.

T #15 sees what she calls a "spiritual awakening" happening with her clients where they may have spiritual types of experiences such as past-life memories or expansion of awareness. These experiences of her clients have not typically initiated a crisis; that is, these experiences do not typically scare her clients to such a degree that they were put "off-center." She credits this mostly to the relatively healthy population she sees.
Summary

Dramatic experiences and unusual states of mind are usually diagnosed by traditional psychiatry as mental disorders. Some of these experiences may actually be crises of personal transformation and can be called spiritual crises or spiritual emergencies. These types of episodes have been described in sacred literature of all ages as results of meditative practices and signposts of the mystical path (Grof & Grof, 1989). While some of the symptoms of a spiritual emergency can be similar to psychotic episodes, theoreticians and clinicians have observed there is a distinction between the two. When these states of mind, called spiritual crises or spiritual emergencies are properly understood and treated in a supportive manner rather than suppressed by psychotropic drugs, they can be healing and beneficial to the person who experiences them.

Mainstream psychiatric theory and practice does not make a distinction between psychopathology and spiritual emergency. The medical model underlying psychiatry tends to pathologize all unusual states of minds. There is a lack of training of mental health professionals in distinguishing between spiritual emergency and psychopathology.
It would be useful for mental health professionals to have a standard method of distinguishing between psychopathology and spiritual crisis so that proper treatment for each can be facilitated. It is the purpose of this study to determine what criteria therapists are using to distinguish between spiritual emergency and psychopathology. The research question is: what criteria are therapists using in their clinical practice to distinguish between spiritual crisis and psychopathology?

The literature review covered the growth model of mental illness, including a description and history of the mystical experience. Literature explicating the similarities between mental illness and spiritual experiences was reviewed. The medical model is reviewed, as well as the theoretical underpinnings for the current methods of classifications of psychopathology. A new paradigm that has been suggested by researchers which takes into consideration new developments in science and physics was reviewed. Writings about transpersonal psychology, a psychological approach that includes spiritual realms of the human being and is in accordance with these new scientific discoveries, are examined. Finally, literature on the distinction between spiritual emergency and psychopathology and forms of spiritual emergency was considered.

The descriptive method of research was utilized in this study. A survey in the form of an interview was conducted on the phone with fifteen transpersonally-oriented therapists in clinical practice. The therapists were
asked how they made the distinction between spiritual emergency and psychopathology in their clinical practice.

The results of the study were that all therapists but one made a distinction between psychopathology and spiritual emergency in their clinical practice. Most of the criteria named by the therapist in the interviews was in accordance with the criteria reviewed in the literature.

**Conclusions**

The most frequent response elicited indicated that the therapist makes a distinction between a spiritual emergency and psychopathology by assessing whether the client is a danger to self or others. Seven therapists named this criteria as a method of making the distinction. This response is in accordance with Grof & Grof (1990), see Table III, pg. 38-40, who state "violations of basic rules of therapy ('not to hurt oneself or anybody else')..." would indicate that psychopathology is probably occurring. Sannella (1992) also states that when a client is dangerous to themselves or others, mental illness would be suspected.

Six therapists interviewed responded that they assess their clients' ability to function in their daily life by looking at whether the client is able to hold a job, maintain relationships, etc. Grof & Grof (1990) (Table III, pg. 38-40) refers to "adequate pre-episode functioning" as a criteria for differentiating between psychopathology and spiritual crisis. Many of the therapists who responded this
way may be referring to situations where clients are experiencing a spiritual emergence rather than a spiritual emergency. Table I, pg. 26-27 shows a chart that attempts to explain the difference in symptoms between these two states. A spiritual emergency is more dramatic and may result in more difficulties in daily life. One therapist did state she assesses whether or not the client's life was "reasonably well-put together" prior to the incident. It seems unclear whether or not the therapists interviewed would rule out a spiritual emergency if the client has had adequate pre-episode functioning but is not currently functioning well in their daily life.

Six therapists stated they look at whether there is a history of psychosis or other mental illness or prior psychiatric hospitalization. These responses are in concurrence with Grof & Grof (1990), Table III, pg. 38-40, who state that "no serious psychiatric history" would indicate spiritual emergency in a client while a "long history of psychiatric problems" would indicate psychopathology.

Four therapists stated they assess the degree of ego strength in their client in making a distinction between spiritual emergency and psychopathology. Examples of ways therapists determine ego strengths are how they deal with reality, can they differentiate their thoughts from others, do they possess an "internal locus of control," does the client know what he/she feels, etc. Grof & Grof (1990), Table III, pg. 38-40, address similar issues by stating the client suspected of having experienced a spiritual emergency has "awareness of intrapsychic nature of process, satisfactory ability to distinguish between the
inner and the outer, 'owning' the process, ability to keep it internalized."

Five therapists stated they make the distinction by assessing whether the client can separate the spiritual experience from normal reality. This is related to the response of "good ego strengths" and is addressed by Grof & Grof (1990) as stated in the above paragraph. These responses are also in accordance with Sannella (1992) who states that when clients who are not psychotic hear voices, they are perceived as coming from within and not outside oneself.

Four therapists stated they pay attention of their "gut-level" reaction or to their intuition in making the distinction between spiritual emergency and psychopathology. These responses are in accordance with Sannella's (1992) comments that clinicians have a sense for the "smell" of psychosis.

Three therapists assess whether the client is "grounded" in making the distinction. One therapist described grounding as the client being congruent with their voice, words, and body language, and a sense that the client feels "centered" in their body. "Groundedness" per se was not specifically addressed in the literature reviewed but is similar to "good ego strengths" previously noted.

Two therapists look at whether the client is using the spiritual experience to avoid personal issues. This issue was not specifically addressed in the literature reviewed, but is a similar issue to that noted by Grof & Grof (1990), Table III, pg. 38-40, when they note that those undergoing spiritual emergency generally have the ability to cooperate and relate, and are able to "own" their
process. These responses by the therapists seem to be implying that the therapists are assessing whether there is honesty and responsibility by the client occurring in the therapeutic process.

Two therapists assess whether the client is experiencing high levels of panic, anxiety, or fear. This may again be an issue of whether the therapist is looking at a spiritual emergence or spiritual emergency. In a spiritual emergency (see Table I, pg. 26-27), there typically may be higher levels of fear and anxiety. Again, it seems unclear whether the therapists responding as such would rule out a spiritual emergency in favor of psychopathology in these cases.

One therapist looks for patterns of possible pathology in the client's life outside of the spiritual emergency. In general, this criteria is addressed by Grof & Grof (1990), Table III, pg. 38-40 repeatedly, e.g., "serious difficulties in interpersonal relationships," "long history of psychiatric problems," "incoherency," "basic mistrust," "destructive and self-destructive impulses," etc.

Fragmentation in the client's thinking was one method a psychiatrist interviewed stated he made the distinction. This is in accordance with Grof & Grof (1990), Table III, pg. 38-40, "disorganization of psychological functions...loosening of associations, incoherence."

One therapist looks at whether the client is acting in an ethical way. This is similar to Grof & Grof's (1990), Table III, pg. 38-40, comment about whether the client is taking responsibility for themselves and their therapy ("owning the
process"), and whether the client is a danger to self or others.

One therapist looks at whether the client is curious and surprised about the spiritual experience. This criteria is similar to Sannella (1992) when he states that those experiencing spiritual emergency have an interest in sharing the experience.

One therapist looks for specific themes occurring in spiritual emergency. This is an important criteria of Grof & Grof (1990), Table III, pg. 38-40, "sequences of biographical memories, themes of birth and death, change and development of themes, often definable progression...."

One therapist stated that she looks at family history of mental illness. This was not a criteria named in the literature reviewed.

Nearly all responses of the therapists interviewed were in accordance with the literature reviewed on the distinction between psychopathology and spiritual emergency. Many therapists named several criteria, but none named the entire repertoire cited in the literature.

Two responses seemed to be more related to the distinction between spiritual emergence and spiritual emergency. These therapists may be recognizing spiritual emergence as distinct from psychopathology, but not spiritual emergency. As one therapist stated, she doesn't see many clients with a spiritual emergency because "it's a new paradigm and most clients stay hidden and get medicated."

In summary, all therapists but one defined at least one criteria they use
to make the distinction between spiritual emergency and psychopathology in clinical practice. The average number of criteria named by a therapist was 3.5. The one therapist who did not name any criteria explained that she viewed all psychopathology as having a spiritual nature and so would not make any distinction between the two.

**Recommendations**

In response to comments by the participants in this study, the following recommendations were developed. Several therapists interviewed expressed concern about the attempt of the researcher to make a distinction between mental illness and spiritual emergency. In general each expressed the idea that all forms of psychopathology were spiritual emergencies and that clients benefit when the therapist views that client from a spiritual perspective. One therapist related how a client was greatly relieved and showed improvement after the therapist helped her view her difficulties from the perspective of a spiritual emergency rather than as psychopathology. This brings up the issue of the stigmatizing effect of diagnostic labels. They can at times do more harm than good.

This brings to the researcher's attention the need for a paradigm switch. Many of the therapists interviewed did not view clients from the perspective of the medical model. Yet to function in our society's institutions, for insurance reimbursement, and for diagnosis in agencies, the therapists were forced to
utilize the medical model. Evidently mental health agencies, hospitals, clinics as well as the insurance industry and the psychiatric medical establishment lag behind human experience and need. Research needs to be done on how to make these institutions more responsive to changing human perspectives and theoretical models. How can we bring about this needed change in these institutions?

One therapist mentioned that language does not allow for adequate expression of spiritual types of experiences. She suggests a new language or new words need to be invented to help us learn to speak of this phenomena.

In addition, the researcher recommends several areas where research is needed. The research results of this study indicate that many of the therapists interviewed are making the distinction between spiritual emergency and psychopathology in their clinical practice. More research needs to be done to determine effective treatment strategies for individuals experiencing spiritual emergencies.

The results of this study seem to indicate that some therapists may be confusing spiritual emergency (as opposed with spiritual emergence) with psychopathology. These therapists seem to be recognizing spiritual emergence (the less dramatic and disturbing form of spiritual experience), but may not be distinguishing between spiritual emergency and psychopathology. More research needs to be done on how therapists are making a distinction between spiritual emergence, spiritual emergency, and psychopathology in clinical
practice.

Although many therapists were making a few distinctions between spiritual emergency and psychopathology in their clinical practice, few, if any, had a systematic method of making the distinction. Few utilized a wide array of criteria, the average number of criteria utilized was 3.5. The literature reviewed names many more criteria that can be utilized to make the distinction. More education and training is needed so that therapists have available a wider range of criteria to utilize in making the distinction between spiritual crisis and psychopathology in their clinical practices.

In the course of undertaking the literature review, the researcher noted that Grof & Grof (1990) state that "spiritual emergency is a combination of transpersonal, perinatal, and biographical experiences" (p. 256). More research is needed to help differentiate these three elements in clinical practice in order to provide effective treatment that takes all three elements into consideration.

In conclusion, the researcher's opinion of the meaning of the results of this study is that the therapists who participated do make a distinction between psychopathology and spiritual crisis of clients in their clinical practices. These distinctions are made in a number of ways that have been noted in the previous section of this chapter. The criteria named by therapists in this study could be utilized in developing standards for clinicians for making the distinction between psychopathology and spiritual crisis in their clinical practices.
REFERENCES


