‘‘Spiritual Emergency’ – a useful explanatory model?’
A Literature Review and Discussion paper

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Introduction

A major complaint from service users is that mental health services, and especially psychiatrists, ignore or pathologise the spiritual aspect of life. There has recently been an increased interest in spirituality and religion in the Australasian psychiatry literature [1-10], and the first British Mental Health, Well-being and Spirituality conference was held in Scotland in 2004. In these contexts, the term "spirituality" is understood in a number of ways. It includes a personal sense of ultimate purpose, meaning and values; a sense of the holy or sacred; a sense of connectedness. It can encompass belief in, and relatedness to, a transcendent reality, higher being or higher power. It can be, but is not necessarily, experientially synonymous with religious ritual, belief and practice, which tends to involve more of an institutional context and a more or less identifiable community of believers. There has not, however, been an understanding of the relationship between spirituality and mental health within mainstream Psychiatry to guide service providers in supporting the recovery movement in this respect, despite (in New Zealand) the National Mental Health Standard's provision for valuing spirituality [11], and the identification of the vital role of "the S-Factor" by the Royal Commission on Social Policy [12], and (in Britain) the increasingly explicit exploration of the spiritual/transpersonal dimension in healthcare (Turvey in press). Maori culture has always recognised an understanding of Taha Wairua, Tapu, Mate Maori, and Makutu as an integral part of hinengaro (mental health) [13,14], but in the context of Psychiatry spiritual experiences and religion have historically tended to be pathologised or ignored.

"Spiritual Emergency" – a useful explanatory model?

A major contribution to this field was made when, in 1994, "Religious or Spiritual Problem" became a new diagnostic category (code V62.89) in the Diagnostic and Statistical Manual of Mental Disorders (DSM 1V). This is not a pathological category, but 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 organised church or religious institution." [37]. (see http://www.spiritualcompetency.com/)

Inclusion of this category followed a number of publications by professor of psychology, David Lukoff, who has also written a personal account of his own experience of believing himself to be a reincarnation of Buddha and Christ, and his subsequent call to "become a healer", which he interprets as a form of

spiritual emergency he identifies as a Shamanic crisis [38]. Lukoff et al [16] documented evidence of the "religiosity gap" between clinicians and patients, and suggested that this represents a type of cultural insensitivity toward individuals who have religious and spiritual experiences in both Western and non-Western cultures. They subsequently pointed out [39] that the impetus for the proposal had come from transpersonal clinicians whose initial focus was on "spiritual emergencies", arising from clinical and personal experience, but this notion was not ultimately included in the DSM 1V description, because of the difficulties relating to diagnostic issues. The phenomenology of what might be interpreted as a "spiritual emergency" by the person or by an informed clinician, can be identical to other psychoses – people can present as disoriented, fearful, hallucinated, delusional, affectively dysregulated, and having interpersonal difficulties – thus making differential diagnosis difficult. Anecdotally, the content revolves around spiritual themes, including sequences of psychological death and rebirth, encounters with mythological beings, feelings of oneness and other similar motifs. Many of these states can be extremely distressing and sometimes terrifying. People who see themselves as experiencing "spiritual emergency" are usually open to exploring the experience, and have no conceptual disorganisation. Good prognostic signs are the same as for other forms of psychosis.

Recent debate has distinguished between validity and utility in psychiatric diagnosis [40]. The notion of diagnostic utility [41] might be more helpful in this context in terms of the capacity for the concept of "spiritual emergency" as an explanatory model to more effectively support the recovery journey of some people because of its normalising and destigmatising potential,

Kleinman [22] has written extensively about the process of selecting and using explanatory models in therapy, and the value judgements, implicit and explicit, that this implies. Clinician and patient may not have similar explanatory models; this difference is extreme if the patient's model is itself seen as evidence of psychosis by the clinician. It may be that there does not need to be an either/or approach taken here, but that both/and explanations might help bridge the 'gap' between "explanation" and "understanding". It is possible both for the clinician to hold a pathological explanation for the phenomenology (e.g. a clearly ictal event) and for the patient to hold an explanation involving spiritual meaning. More research attention is being paid to the importance of the patient's explanatory models in recovery [23]. The notion of "narrative competence" – "the ability to absorb, interpret, and act on the stories and plights of others" [24] is helpful here. This concept is gaining increasing credibility and applicability within clinical medicine, but has not yet found a place within Psychiatry, which has tended to focus more on the form than the content of the person's narrative.

The evidence presented below points towards the likelihood that there is "clinical utility" in the notion of "spiritual emergency" as an explanatory model, and thus potentially as a diagnosis if future revisions of DSM were to be based on utility criteria [40]. Lukoff et al. [38, 39] stress the need for more research to better understand the prevalence, clinical presentation, differential diagnosis, outcome, treatment, relationship to the life cycle, ethnic factors, and predisposing

intrapsychic factors related to religious and spiritual problems. For diagnostic utility of "spiritual emergency" to be demonstrated, user acceptability and improvement in outcome would need to be measured in addition.

Literature Review and Research Findings

Research specifically related to the notion of "spiritual emergence" and "emergency" is very limited. Because these notions are not widely used in psychiatric literature, it is unclear to what extent these phenomena may be playing a part in the experience of people undergoing serious mental illness, or to what extent this concept might be helpful if introduced to people in recovery from psychosis. The following research findings are detailed in a review by Koenig et al [42]. Generally people diagnosed with serious mental illness are at least as likely as the general population to feel that spiritual and religious beliefs and practices have a positive impact on their illness, and to identify themselves as having spiritual needs, such as the need to know God's presence and the need for prayer. Little research has been done on the effects of these issues on mental health outcomes, although rates of depression and alcohol abuse are reported as lower among religious persons. Two randomised clinical trials demonstrated significantly faster recovery from depression when Christian religious psychotherapy was used compared with CBT, and from anxiety symptoms when Muslim religious psychotherapy was used compared with traditional treatment. Findings demonstrated that seriously mentally ill people tend to pray more and attend church less than others. Both clergy and mental health professionals are likely to see persons with the same severity of clinical diagnoses [42]. Certain religious practices (such as worship and prayer) appear to protect against severity of psychiatric symptoms, hospital use and enhance life satisfaction [43].

Case Reports

Lukoff et al. [44] argue that despite the disrepute in which case studies are generally held, they are still a primary mode of transmitting knowledge, They note that cases in which a focus of therapy involves a religious or spiritual problem are not easy to find and they give a number of brief case histories to exemplify each type.

Medline and Psycinfo searches for case reports supporting the concept of spiritual emergence and spiritual emergency revealed seven individual published cases [45-50, 37]. Internet sites (www.internetguides.com and www.psyspiritstory.co.uk) revealed eight personal accounts of people recovering from psychotic experiences that were interpreted as having spiritual value. Further accounts are published in "Taking Spirituality Seriously" [51]. "The dark night of the soul" and spiritual emergency are implicated in understanding the recent tragedy in Japan involving Aum Shinrikyo cult members [52]. Caygill [53] presents a personal account of major depression as a Dark Night of the Soul experience. Greenberg et al. [54] describe the cases of four young men who explored Jewish mysticism and became psychotic. The authors state that it is

apparent in these descriptions that hallucinations, grandiose and paranoid delusions, and social withdrawal do not distinguish the psychotic from the mystic. Similarly, three detailed cases are presented, drawn from a larger study of ten cases, showing that psychotic phenomena can occur in the context of spiritual experiences rather than mental illness [55]. In these cases, pathological and spiritual psychotic phenomena cannot be distinguished by form and content, but need to be assessed in the light of the values and beliefs of the individual concerned. Quantitative methodology was similarly used to compare the incidence of "delusional ideation", according to PSE criteria, in people belonging to New Religious Movements (NRMs), non-religious people, Christians and psychotic in-patients [56]. Those in the NRM group could not be distinguished from in-patients in terms of all delusional measures apart from level of distress. These findings support the notion of a continuum between normality and psychosis, the possible biological basis of which has been explored by Claridge [57].

Sannella [58] details 15 case histories of Kundalini (or "physio-Kundalini") experiences, regarded as one of the most frequently encountered forms of spiritual emergency [36]. Bentov [59] outlines the possible physiological mechanism of this phenomenon, which is described in classical yoga literature, and refers to the flow of "energy" through the chakra system (a series of seven "centres" located opposite the major nerve plexuses in the abdomen and thorax, neck and head), and is thought to be a healing and "unblocking" process.

Qualitative Studies

A number of qualitative studies have included questions relating to spiritual development, spiritual emergency and recovery. Some of these are detailed below. For example, Hood [60] conducted qualitative research with ten subjects who had each experienced an identified spiritual emergency, using in-depth interviews and written documents. The findings include a listing of precipitating factors; feelings and emotions during the experience; how the experience was integrated into the individual's life; and what was or was not helpful during the spiritual emergency.

Regner [61] conducted a descriptive and exploratory study using first hand accounts of four subjects, including her own, who identified themselves as having experienced Christian conversions, and who understood their transformations as "work of the Holy Spirit as well as Kundalini awakening". She introduces the notion of spiritual emergency, using a case study to outline the difficulties in differential diagnosis when symptoms of mental illness and signs of spiritual awakening occur together.

Fallot [62,63,20] analyses the key religious and spiritual themes in recovery narratives drawn from spiritual discussion groups, trauma recovery groups and other clinical contexts at Community Connections, a mental health facility for people diagnosed with severe mental illness. Although at times organised religion has been experienced as stigmatising and rejecting, on the whole personal spiritual experience of relationship with God has been helpful in building identity, self-responsibility, hope, a sense of divine support and love, the courage to

change and an acceptance of what can't be changed, an increased sense of authenticity, connection with faith communities, and the discipline of prayer and meditation, religious ritual, reading and music.

Jacobson [64] applied the technique of dimensional analysis to 30 recovery narratives in order to discover the uniqueness of the recovery process. Under the component process of "recognising the problem", she identified "spiritual or philosophical" as one theme and identifies spiritual emergency, as an explanatory model, although this term is not specifically applied. She comments "The greatest help comes when individuals are able to connect with some source of enlightenment; a community of practicing Buddhists, the Bible, treatises of philosophy or physics. Recovery is about enduring and coming out the other side; the rebirth that follows the death."

Discussion

"Spiritual illiteracy" – a barrier to recovery

We live in an age suffering from spiritual illiteracy (both within and outside psychiatry). This has created a barrier within psychiatry which has made it difficult so far to incorporate and benefit from research findings such as those above, despite recent attempts to do so [15]. In contrast to the scientific frame of psychiatry, most people in the world are religious and hold beliefs about God as important. Many people report specific religious experience of a divine or transcendental nature [17,18].

Recently, in both New Zealand and Britain, there has been a focus on "recovery" as a possibility, and as a goal for people using Mental Health Services [19]. One of the major factors identified as facilitating recovery is hope. Many patients say that spirituality plays a vital role for them in bringing hope, empowerment, identity, and a sense of purpose and meaning that are crucial for their recovery from serious mental illness [20].

Overcoming the barrier

a). Understanding the relationship of psychosis and spirituality

The spiritual aspect of a person's life can be related to psychosis in various ways:

(1) an important part of the context of their life which affects many of their normal values, ideas, and behaviours
(2) an area of life affected by the psychosis
(3) a potential area of support in their care and recovery
(4) a domain from which an explanatory model comes

In comparison, a marital relationship could be related to psychosis for similar points (1) – (3) but not really for (4). Psychiatrists would assume they should be interested in a person's marital life for these reasons. They are wary of using the same logic for spiritual life because they are less confident in their understanding of spirituality and lack a good language for this area. While a clinician is highly likely to see marital stress or change as significant precipitating, or perpetuating factors in psychosis, they are much less likely to recognise spiritual changes as precipitant or perpetuating factors. This presents a particular problem if the person's explanatory model includes a spiritual component which the clinician is unable or unwilling to work with this – hence the importance of having a framework with which to proceed effectively.

b) Spiritual Assessment

Fallot [25] identifies the need for assessment of spirituality by mental health services in order to evaluate spiritual experiences and their function. He proposes an assessment tool featuring a grid with the following factors; 'beliefs and meaning', 'experience and emotion', 'rituals and practice', and 'community' on one side, with 'explicitness of religious language' and 'role in patient's overall well-being' across the top. A tool such as this could potentially help the clinician to understand the role spirituality plays in the person's life, and perhaps how to assist the person with further spiritual growth (for example, by introducing the concept of spiritual emergency if appropriate), but may need to be used by an appropriately trained person (e.g. a chaplain), and training of mental health service staff would also be required. D'Souza [2] also advocates for incorporating a spiritual history into psychiatric assessment. Griffiths and Griffiths [21] detail how even clinicians who themselves do not hold a spiritual frame of reference can learn to talk helpfully with people about their spiritual lives, and to facilitate the development of spiritual and religious beliefs and practices that promote existential resilience, rather than existential vulnerability. The spiritual part of a person's life can also be incorporated into a "Strength's Model" assessment and recovery plan.

c) Spiritual Growth or Development

Piaget's human development stops at Formal Operations. Abilities at this level support the basic scientific view of the world and the medical model of mental illness, which tend to underpin the practice of psychiatry. Many authors have suggested or described development beyond this stage (notably Wilber's transpersonal stages [26]).

Many models of spiritual/faith development have been proposed [27-34]. The general emphasis is on the fact that spiritual development is a natural part of human development, and all people, whether they recognise or acknowledge

this, have the potential to develop spiritually, just as they have the potential to develop physically, psychologically, cognitively, socially, morally etc.

It is beyond the scope of this paper to discuss these centrally important concepts in further detail.

d) Application of "Spiritual Emergence and Spiritual Emergency" as explanatory model

When spiritual development is gradual and occurs in a context which can support the personal changes in worldview that it brings, there should be no crisis of transition. When it is sudden, or the higher stage is experienced intermittently there can be uncertainty or crisis. In this context, Grof and Grof [35, 36] write about spiritual development using the term "spiritual emergence". By this, they mean "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". They go on to make a distinction between this natural process, and a more difficult and sometimes traumatic experience, ".When spiritual emergence is very rapid and dramatic, however, this natural process can become a crisis, and a spiritual emergence becomes a 'spiritual emergency'". Episodes of this kind have been described in the sacred literature of all ages as a result of meditative practices and are signposts of the mystical path.

Recovery from psychosis and care for spiritual emergency

In a psychosis formulated as a spiritual emergency best care will both use the spiritual sphere to speed recovery and avoid iatrogenic damage. There are some similarities to general crisis intervention that sees crisis as a time of opportunity. Psychosis appropriately framed as "spiritual emergency" can be seen as an opportunity for further personal growth, if responded to in appropriate ways.

Treatment of spiritual emergency is supportive, does not usually involve medication (other than occasional use of a minor tranquilliser or hypnotic to ensure sleep if necessary). Care is usually undertaken by people who have a transpersonal understanding and some experience themselves of these phenomena. It involves "being with" the person, usually in a tranquil environment, doing everyday things to help "ground" the person. Reception of the altered state is characterized by trust rather than fear, with the expectation that healthy, natural resolution will occur in time, with a beneficial outcome in terms of personal growth. Sometimes constant supervision can be necessary to help prompt care of basic needs, such as eating and drinking, if these are being neglected. Cessation of intense spiritual practices at this time is usually recommended, but prayer support may be offered. Explanation of the psychotic experience in terms of the spiritual domain is helpful. The person is supported in expressing the content of their inner world at their own pace, and when

appropriate, the psychospiritual roots of the problem can be addressed. For this type of care to become available within general mental health services, clearly appropriate staff selection and training would be required [65, 66].

The danger for people being diagnosed as having a serious form of psychotic disorder is that they will be subjected to perhaps unnecessary, suppressive antipsychotic medication, with its potentially serious side effects. If psychosis can be seen as "a state of aberrant salience", and a central role of dopamine is to mediate the "salience" of environmental events [67] it may be that the "salience" of the experience of spiritual emergency is inappropriately suppressed by dopamine blockade. In addition, there may be the social isolation, stigmatisation and self-stigmatisation associated with the label of mental illness. This may leave the person not only with the need to integrate the spiritual emergency experience without a context in which to understand it, but also having to recover from the trauma of these consequences.

On the other hand there are risks associated with not treating psychosis with medication soon enough related to on-going distress, potentially unwise or dangerous behaviour, and effect on prognosis. Current best practice recommends early use of antipsychotics for all acute psychosis in an attempt to prevent the deteriorating pattern of chronicity [68]. With the burgeoning of early intervention programmes this balance of risks is an aspect which needs urgent attention. The concept of spiritual emergency is a potentially useful explanatory model which might assist in the recovery process because it is normalising and not stigmatising. It remains unclear how large the sub-group of patients is for whom this explanatory model, and an approach which supports spiritual development and understanding of the psychotic phenomena in this light, might be more useful either in the acute management phase or recovery phase. Further research is recommended in order to assess whether the notion of spiritual emergency might have diagnostic utility in improving clinical outcome for this sub-group and how cases can be identified in terms of past history, phenomenology, continuity with prior spiritual life, and personal explanatory model. To what extent spiritual emergency may be 1) a separate diagnosis strongly related to causal factors and best treatment or 2) an explanatory model that is useful for some people recovering from psychosis, regardless of cause, which can be included along with other treatment approaches, are important questions to be answered.

Bibliography

1. Halasz G. Can psychiatry reclaim its soul? Psychiatry's struggle against a dispirited future. *Australasian Psychiatry* 2003; 11(1) 9-11.
2. D'Souza R. Incorporating a spiritual history into psychiatric assessment. *Australasian Psychiatry* 2003; 11(1) 12-15.
3. Meadows G. Buddhism and psychiatry: confluence and conflict. *Australasian Psychiatry* 2003 ;11(1) 16-19.
4. Clarke D. Faith and Hope. *Australasian Psychiatry* 2003 ;11(2) 164-168.

5. Keks N, D'Souza R. Spirituality and psychosis. *Australasian Psychiatry* 2003; 11(2) 168-171.
6. Mathai J, North A. Spiritual history of parents of children attending a child and adolescent mental health service. *Australasian Psychiatry* 2003;11(2) 172-174.
7. Browning D. Internists of the mind or physicians of the soul: does psychiatry need a public philosophy? *Australian and New Zealand Journal of Psychiatry* 2003; 37 (2)131-137.
8. Quadrio C. Commentary *Australian and New Zealand Journal of Psychiatry* 2003;37 (2) 138-140.
9. Harari E. Commentary. *Australian and New Zealand Journal of Psychiatry* 2003; 37(2) 140-142.
10. Bathgate D. Psychiatry, religion and cognitive science. *Australian and New Zealand Journal of Psychiatry* 2003; 37(3) 277-285.
11. New Zealand Standards *The National Health Sector Standards* Wellington NZ 58143. 2001.
12. Benland C. The S-Factor – Taha Wairua. The dimension of the Human Spirit. The April Report: Future Directions; *Report of the Royal Commission on Social Policy* 1988; 3(1) 451-465.
13. Durie M. Mauri Ora. *The Dynamics of Maori Mental Health,* Melbourne, Oxford University Press, 2001.
14. Lyndon G. *Beliefs in Tapu, Mate Maori, and Makutu and the relevance of these beliefs to the diagnosis of mental illness amongst Maori.* University of Auckland thesis, 1983.
15. Clarke I. Psychosis and Spirituality: The discontinuity model. In I. Clarke (Ed.), *Psychosis and Spirituality: Exploring the New Frontier.* London: Whurr Publishers Ltd, 2001.
16. Lukoff D, Lu F, Turner R. Toward a More Culturally Sensitive DSM-1V. *Journal of Mental Diseases* 1992; 180, 673-682.
17. James W. *The Varieties of Religious Experience* (First Touchstone Edition). New York: Simon & Schuster 1997.
18. Hardy Sir A. *The spiritual nature of man. a study of contemporary religious experience 1896-1985.* Oxford. Clarendon. 1979. 1983 [printing].
19. Mental Health Commission. *Book of Collected Articles. A Companion to: Mental Health Recovery Competencies Teaching Resource Kit.* Wellington. New Zealand: Mental Health Commission. 2001.
20. Fallot R. D. Spirituality and religion in psychiatric rehabilitation and recovery from mental illness. *International Review of Psychiatry* 2001; 13(2), 110-116.
21. Griffith JL, Griffith ME. *Sacred Encounters in Psychotherapy: How to talk with people about their spiritual lives.* New York: Guilford Press. 2002.
22. Kleinman A. *Patients and healers in the context of culture.* Berkely: University of California Press. 1980.
23. Geekie J. Listening to the voices we hear: client's understanding of psychotic experiences. In: Read J, Mosher L, Bentall R, eds. *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia.* London. Brunner-Routledge. 2004.

24. Charon R. Narrative Medicine: A model for Empathy, Reflection, Profession, and Trust. *Journal of the American Medical Association* 2001; 286: 1897-1902
25. Fallot RD. Assessment of spirituality and implications for service planning. In: Fallot, RD, ed. *Spirituality and religion in recovery from mental illness New Directions for Mental Health Services*, 1998; 80 :13-23 .
26. Wilber K. Integral Psychology. *Consciousness, Spirit, Psychology, Therapy.* Boston and London: Shambhala, 2000.
27. Fowler J. W. *Stages of Faith.* San Francisco: HarperSanFrancisco. 1981.
28. Clinebell H. *Growth Counselling.* Nashville: Abingdon. 1979.
29. Peck S. *The Different Drum. The creation of true community - the first step to world peace.* London, Sydney, Auckland, Johannesburg: Rider, 1987.
30. Ruumet H. Pathways of the Soul. *Presence: The Journal of Spiritual Direction International* 1997; 3(3), 7-25.
31. Rolheiser R. *The Holy Longing. The Search for Christian Spirituality.* New York, London, Toronto, Sydney, Auckland: Doubleday, 1999.
32. Zohar D, Marshall I. *SQ. Spiritual Intelligence The Ultimate Intelligence*. London, Bloomsbury, 2000.
33. Hawkins D. *Power Versus Force: An Anatomy of Consciousness. The Hidden Determinants of Human Behaviour*. Brighton-Le –Sands NSW. Hay House Australia Pty Ltd, 1995.
34. Marion J. *Putting on the Mind of Christ. The inner work of Christian Spirituality.* Charlottesville, VA: Hampton Roads. 2000.
35. Grof C, Grof S. *The Stormy Search for the Self - A Guide to Personal Growth through Transformational Crisis.* New York: Jeremy P Tarcher, 1990.
36. Grof S. *Spiritual Emergency. When Personal Transformation becomes a crisis.* Los Angeles: Jeremy P. Tarcher, 1989.
37. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (4th edition)* Washington DC: American Psychiatric Association, 1994.
38. Lukoff D. The importance of spirituality in mental health. *Alternative Therapies* 2000; 6(6), 81-87.
39. Lukoff D, Lu F, Turner R. From spiritual emergency to spiritual problem: The transpersonal roots of the new DSM-IV category. *Journal of Humanistic Psychology* 1998; 38(2), 21-50.
40. Kendall R, Jablensky A. Distinguishing between the validity and utility of psychiatric diagnoses. *The American Journal of Psychiatry* 2003;160:4-12.
41. First MB, Pincus HA, Levine JB, Williams JB, Bedirhan U, Peele R. Clinical utility as a criterion for revising psychiatric diagnoses. *The American Journal of Psychiatry* 2004; 161:946-954.
42. Koenig HG, Weaver J. Research on Religion and Serious Mental Illness. *New Directions in Mental Health Services* 1998; 80, 82-95.
43. Baetz M, Larson DB, Marcoux G, Bowen R , Griffin R. Canadian psychiatric inpatient religious commitment: an association with mental health.[comment]. *Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie* 2002. 47(2), 159-166.

44. Lukoff D, Provenzano R, Lu F,.Turner R. Religious and Spiritual Case Reports on Medline: A Systematic Analysis of Records from 1980 to 1996. *Alternative Therapies* 1999; 5(1), 64-70.
45. Lukoff D. The myths in mental illness. *Journal of Transpersonal Psychology* 1985; 17(2), 123-153.
46. Hendlin SJ. The spiritual emergency patient: Concept and example. *Psychotherapy Patient* 1985;1(3), 79-88.
47. Ossoff J. Reflections of Shaktipat: Psychosis or the rise of Kundalini? A case study. *Journal of Transpersonal Psychology* 1993; 25(1), 29-42.
48. Whitney E. Mania as spiritual emergency. *Psychiatric Services* 1998; 49(12), 1547-1548.
49. Khouzam HR, Kissmeyer P. Antidepressant treatment, posttraumatic stress disorder, survivor guilt, and spiritual awakening. *Journal of Traumatic Stress* 1997; 10(4), 691-696.
50. Chadwick P. Sanity to supersanity to insanity: A personal journey. In I. Clarke (Ed.), *Psychosis and Spirituality: Exploring the New Frontier.* London and Philadelphia: Whurr, 2001.
51. Clarke I. Special Issue: Taking spirituality seriously. *Journal of Critical Psychology, Counselling and Psychotherapy* 2002.; 2(4), 201-267.
52. Kogo Y. Aum Shinrikyo and spiritual emergency. *Journal of Humanistic Psychology* 2002; 42(4), 82-101.
53. Caygill M. *"Have You recovered from that little lapse you had?"* Paper presented at the Through The Whirlwind. Disability, Faith and Spirituality Conference, Wellington, 2003.
54. Greenberg D, Witztum E, Buckbinder JT. Mysticism and Psychosis: The fate of Ben Zoma. *British Journal of Medical Psychology* 1992; 65, 223-235.
55. Jackson M, Fulford KWM. Spiritual Experience and Psychopathology. *Philosophy, Psychiatry, & Psychology* 1997; 4(1), 41-65.
56. Peters E, Day S, McKenna J, Orbach G. Delusional ideation in religious and psychotic populations. *British Journal of Clinical Psychology* 1999.; 38(Pt 1), 83-96.
57. Claridge G. Spiritual experience: healthy psychoticism? In: Clarke I, ed. *Psychosis and Spirituality: Exploring the New Frontier*. London. Whurr Publishers Ltd. 2001.
58. Sannella L. *Kundalini - Psychosis or Transcendence?* San Francisco: H S Dakin Company, 1981.
59. Bentov I. Micromotion of the Body as a Factor in the Development of the Nervous System. In: Sanella L, ed. *Kundalini - Psychosis or Transcendence.* San Francisco: H S Dakin Company, 1981.
60. Hood BL. *Spiritual Emergencies: Understanding transpersonal crises.* University Massachusetts, thesis, 1987.
61. Regner VA. *Re-examining Christian conversion experiences: Considering Kundalini awakenings and spiritual emergencies.* School Of Theology At Claremont, US, thesis. 1999.
62. Fallot RD. Spirituality in trauma recovery for people with severe mental disorders, In: Harris M, Landis CL ,eds. Sexual abuse in the lives of women

diagnosed with serious mental illness. *New directions in therapeutic interventions* 1997; 2:337-355 .
63. Fallot RD. Spiritual and religious dimensions of mental illness recovery narratives, In: Fallot R D, ed. *Spirituality and religion in recovery from mental illness New Directions for Mental Health Services* 1998.; 80:35-44.
64. Jacobson N. Experiencing Recovery: A dimensional analysis of recovery narratives. *Psychiatric Rehabilitation Journal* 2001; 24,248-256.
65. Nelson J. E. *Healing the split: Integrating spirit into our understanding of the mentally ill* (Revised ed.). New York: State University of New York, 1994.
66. Grof S. *Psychology of the Future*. Albany, New York: State University Press, 2000.
67. Kapur S. Psychosis as a State of Aberrant Salience: A Framework Linking Biology, Phenomenology, and Pharmacology in Schizophrenia. *American Journal of Psychiatry* 2003; 160: 13-23.
68. Remington G; Kapur S, Zipursky RB. Pharmacotherapy of first-episode schizophrenia. *British Journal of Psychiatry* 1998; 172 (Suppl. 33), 66-70.

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