SPIRITUAL EMERGENCE, SPIRITUAL EMERGENCY
AND MENTAL HEALTH AWARENESS

This document contains the following handouts:

1. The Spectrum of Mental Health
2. Mental Health - Risk and Resilience
3. Spiritual Emergency Overview 1
4. Spiritual Emergency First Aid
5. Spiritual Emergency Overview 2
6. Book List
THE SPECTRUM OF MENTAL HEALTH
Dr Carl Stonier and Sarah Jane Williamson

Borderline Personality Disorder
Strong emotions, mood swings and feelings you can’t cope with very easily. Difficulty in holding down relationships. Helpers often find themselves going way beyond what is reasonable in trying to help. BPD is also somewhat irreverentially called Bullshit Psychiatric Disorder by those who disagree with medicalised psychiatric care. Current thinking is that it is an Attachment Disorder. Diagnoses on the increase.
Kiera Van Gelder, Buddha and the Borderline http://www.buddhaandborderline.com/

Psychosis
There are usually reckoned to be two psychoses, and both have a strong correlation (up to 80%) with an abusive, traumatic or neglectful early life. The latest research debunks the traditional view that the psychoses are largely genetically determined, at least in any simple way, and the current thinking is that there may be small changes in up to 1000 genes which contribute to the development of a psychosis, with early life experiences creating the trigger, or even the genetic expression:

- Schizophrenia
A mental illness which affects the way you think. Not a split personality but the ‘destruction’ of the personality. The person with schizophrenia may not be able to distinguish their own intense beliefs, ideas, thoughts and emotions from reality.
  - Loss of insight. Believes behaviours and beliefs are perfectly normal when they are clearly not to the people around them.
  - Delusions – beliefs not supported by culture or circumstances
  - Paranoia
  - Disorganised thinking
  - Hallucinations – a false sensory perception in the absence of external stimulus, ‘hearing voices’
  - Apathy, social withdrawal

It can be a one off episode of illness with a full recovery (usually the case if treated early) or it can come and go at different periods in life (and this is often diagnosed as Schizo-affective Disorder).

Bipolar Disorder
A psychotic disorder that used to be known as ‘manic depression’. Periods of functional and emotional stability interspersed with episodes of mania and depression. Manic periods may feature elation, over-activity, grandiose beliefs, disorganisation, over-spending, rapid incomprehensible speech. Depressive episodes have a more rapid onset than in ‘unipolar’ depression, are deeper and bring high suicide risk, usually when starting to lift out of the depression, since it is too much effort when in a full depression.
Neurosis
You may hear the term neurosis being used to describe states of mental distress without hallucinations, delusions or other signs of psychosis, but the term has now been dropped from the DSMV and replaced with the term anxiety disorders. It used to include things like anxiety and obsessive compulsive disorder (OCD).

Depression
Feelings of prolonged, severe despair that impair daily life. Low mood, low self esteem, apathy, sleep disturbance. A depressed person may also have racing, repetitive, negative thoughts which are relentless and exhausting. Figures show that there is a year on year increase in antidepressant medication prescribing, with a greater than 9% increase from 2010 to 2011 to almost 50,000,000 prescriptions – and this after a meta-analysis from Hull University concluded that if antidepressant medication is effective, it is no more than 30% so, and most of that can probably be attributed to placebo effect.
Ruby Wax *Sane New World* [http://www.rubywax.net/sane-new-world.html](http://www.rubywax.net/sane-new-world.html)

Self harm
Deliberately causing injury or pain to yourself without intending to kill yourself. People who self harm report that it brings a sense of relief from intense mental distress. It brings a sense of control and physical reality. Psychiatry describes self harming as a dysfunction, but self harmers describe it as functional – they do it because it works at relieving inner pain.

Dissociative Identity Disorder (DID)
This used to be called Multiple Personality Disorder, and always develops as a response to extreme trauma as a child. It is a way of protecting the ‘core self’ by creating other personalities who can hold a particular pain or function, and then go into the background when the event is over. There is usually a day-to-day manager personality who maintains an appearance of normality. Typically, thoughts, feelings, memories, sensations and perceptions disconnect from each other. There may be a sense of things being unreal. There can be regular periods of amnesia. People with DID may express many different personalities and may switch markedly from one to another, have different genders and different physical characteristics and abilities. DID can be very distressing as people with DID are usually fully aware of it and will have developed many coping strategies.
[http://www.mind.org.uk/blog/9654_whats_in_a_name_my_did](http://www.mind.org.uk/blog/9654_whats_in_a_name_my_did)
[http://www.amazon.co.uk/When-Rabbit-Howls-Truddi-Chase/dp/0515103292](http://www.amazon.co.uk/When-Rabbit-Howls-Truddi-Chase/dp/0515103292)

Trauma-related Dissociative Disorders
A number of types of dissociative behaviours that have their roots in early childhood trauma. The body and brain's coping strategies of zoning-out, switching-off, denying hunger or pain, become normalised responses to the everyday and can become unhelpful in adult life. Closely related to PTSD.

Post-Traumatic Stress Disorder
PTSD is a normal reaction to an abnormal event. It can occur after any experience where there was a significant threat to life, so experiences like assault, car crash, bank robbery (especially armed), military/combat experience, rape and extreme abuse in childhood, can all lead to PTSD. PTSD is characterised by re-experiencing symptoms – flashbacks, nightmares,
intrusive thoughts; by avoidant behaviours – emotional numbness, avoiding things which remind you of the traumatic event, depressive symptoms; hyper-arousal symptoms – being on edge all the time; always on the lookout for danger, easily startled, easily angered. PTSD usually responds well to the right sort of therapeutic help, but it may remain dormant for many years before manifesting.

**Anxiety**
Essentially, anxiety occurs when you perceive yourself to be under threat, so that the ‘fight, flight or freeze’ adrenalin response is switched on, but there is no real threat present. It can occur because there was a real threat, and the fear becomes entrenched, or when there never was a threat, but the person imagines that there was one. The physiological response to anxiety is real, and symptoms can include tight chest, churning stomach, feeling/being sick, loss of bladder and/or bowel control, inability to think clearly, running away, regardless of other dangers such as busy roads, dry mouth, ‘jelly legs’, palpitations. Phobias are specific types of anxiety, when there is a clear focus for the anxiety or fear, as compared to generalised anxiety disorder, when the fear encompasses every aspect of life, so that the person affected is, in the worst cases, overwhelmed by fear in all or most situations. It is also known as a panic attack.
[www.anxietyuk.org.uk](http://www.anxietyuk.org.uk)

**Obsessive Compulsive Disorder**
OCD is a particular type of anxiety disorder, characterised, as the name suggests, by obsession and compulsion – “I have to do this (obsession) or ???? will happen (compulsion)”. It typically begins in early teenage years and is often related to the death of someone close, like a grandparent. The ‘logic’ is along the lines of “I didn’t do XYZ, and grannie died, therefore I now have to do XYZ all the time to keep everyone else safe”.

**Dual Diagnosis**

**Learning disability**
Learning disability is often conflated with mental health issues, but is a separate matter. Learning disability is a spectrum of conditions where the person affected has some difficulty in learning new information and knowledge. This may be due to genetic flaws, such as, for example, Down’s syndrome, where there is an extra chromosome number 21 (trisomy 21), or de Lange’s syndrome, where there is an abnormality of chromosome 5 or due to developmental flaws or developmental difficulties, where the ‘normal’ brain development does not happen. There is a huge range of difficulties, from someone who is intellectually very gifted, but dyslexic, to someone who is intellectually very disadvantaged. Mental illness is more likely found amongst those who are also learning disabled.

**Autistic Spectrum Disorder**
ASD is a specific form of developmental learning disability and is also a wide spectrum of abilities. Typically, an autistic person will have difficulty in engaging in relationships or dealing with change, but may well be intellectually or creatively very gifted. Asperger’s syndrome is one form of ASD and, for example, someone with Asperger’s will be literal rather than social “Does my bum look fat in this?” “Yes!”. There are many noted examples of very high functioning autistics such as Prof. Dr Temple Grandin.
[http://www.amazon.co.uk/Aspergers-Love-Couple-Relationships-Affairs/dp/1843101157/ref=sr_1_1?ie=UTF8&qid=1382225069&sr=8-1&keywords=aspergers+in+love+maxine+aston](http://www.amazon.co.uk/Aspergers-Love-Couple-Relationships-Affairs/dp/1843101157/ref=sr_1_1?ie=UTF8&qid=1382225069&sr=8-1&keywords=aspergers+in+love+maxine+aston)
**Mental health**
The ability to cope with life’s challenges and to withstand and recover from trauma, distressing episodes and events.

**Mental illness**
Mental illness has a clearly definable onset after a period of normal functioning. It is a severe and potentially debilitating condition which can have an organic or biological basis which responds to medication designed to rebalance neurotransmitters. Psychotherapeutic, social and practical support are also increasingly becoming recognised as being key to a full recovery along with medicalised approaches.
Mental illness rarely appears suddenly, however, and usually can be traced to or triggered by a stressful or traumatic life event.
Mental illness is increasingly being considered as something from which people can make a recovery to a fully functioning life, especially if treated early. However the stigma of having a mental illness and misunderstandings about treatment options will prevent many people from seeking help in early stages, or people seeking help early may find their symptoms are dismissed by well-meaning GPs. There is still a long way to go before mental illness has parity with physical illness.

**Recovery**
A formal term used during the care, treatment and support of people experiencing a mental illness which covers a range of approaches that support the person to identify and recover quality of life by their own definition.

**Sense of wellbeing**
A sense of wellbeing is the desired mental state, where there are no signs or symptoms of distress, and life is fulfilling. It is, however, hard to define a sense of wellbeing and some people consider the term to be vague, aspirational and not reflective of the complexities and ups and downs of daily life.

**Wellness**
The absence of symptoms of illness or difficulty which reduce quality of life as defined by the person. ‘Wellbeing’ is now being replaced by ‘wellness’ in the mainstream to accurately describe the opposite of illness. Wellness is considered less vague and less aspirational than ‘wellbeing’. ‘Wellness’ implies that we can have symptoms and difficulties and bad days, but on the whole, we are not currently ill, we are well.

**Useful websites:**
- Mind mental health A-Z [http://www.mind.org.uk/mental_health_a-z](http://www.mind.org.uk/mental_health_a-z)
- Rethink mental illness [http://www.rethink.org/home](http://www.rethink.org/home)
- [www.criticalpsychiatry.co.uk](http://www.criticalpsychiatry.co.uk)
- [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)
- Website for people experiencing mental distress and psychosis [http://www.hearing-voices.org/](http://www.hearing-voices.org/)
- For people interested in non-medicalised approaches to mental illness [www.soterianetwork.org.uk](http://www.soterianetwork.org.uk)
MENTAL HEALTH CPD SESSION - RISK AND RESILIENCE

In talking about the spectrum of Mental Health and Mental Illness, we identified that some mental illnesses have a high correlation with adverse life events in childhood. However, correlation does not equal causation, and we need to be careful when reading research studies which imply causation from correlation. Some people will seem to have had a supportive, loving, well-balanced early life and yet be prone to mental illness of one sort or another, and another person may seem to have experienced many events which could be classed as risk factors and yet appear to be resilient and relatively unaffected. There is a constant search to identify what these differential factors may be, and current thinking splits both the risk factors and the resilience factors into 3 distinct parts – those to do with the child, those to do with the family in which the child is raised, and those to do with the wider environment.

<table>
<thead>
<tr>
<th>The child</th>
<th>The family</th>
<th>The environment</th>
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<tbody>
<tr>
<td><strong>Risk Factors</strong></td>
<td></td>
<td></td>
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<tr>
<td>Genetic influences</td>
<td>Deprivation and poverty</td>
<td>Deprivation and poverty</td>
</tr>
<tr>
<td>Learning difficulties</td>
<td>Abuse – all sorts</td>
<td>Poor schooling</td>
</tr>
<tr>
<td>Prolonged physical illness/hospitalisation</td>
<td>Parental, and especially maternal mental illness</td>
<td>Emigration</td>
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<tr>
<td>Developmental difficulties</td>
<td>Inconsistent discipline</td>
<td>Discrimination</td>
</tr>
<tr>
<td>Communication difficulties</td>
<td>Lack of love and affection</td>
<td>Bullying</td>
</tr>
<tr>
<td></td>
<td>Conflict, especially between carers, inc. family breakdown</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Loss, including death of those close – family and friends</td>
<td></td>
</tr>
<tr>
<td><strong>Resilience Factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secure attachment to at least one good enough parent figure</td>
<td>At least one good enough parent figure</td>
<td>Part of wider support network</td>
</tr>
<tr>
<td>Higher intelligence</td>
<td>Affectionate</td>
<td>Good housing and living standards</td>
</tr>
<tr>
<td>Good communication skills</td>
<td>Clear, firm, consistent and fair discipline</td>
<td>Good, secure and affirming schooling</td>
</tr>
<tr>
<td>Sense of control</td>
<td>Supportive</td>
<td>Range of activities</td>
</tr>
<tr>
<td>Sense of humour</td>
<td>Absence of discord within the family</td>
<td></td>
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<tr>
<td>Religious/spiritual belief</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reflexive</td>
<td></td>
<td></td>
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<tr>
<td>Self belief</td>
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By and large, one’s capacity for resilience is established during the first 6 or 7 years of life, but low resilience people can train and improve their base-line resilience and overall confidence, for example through military training, martial arts and personal growth work and self-care strategies. The majority of people who have experienced and recovered from a mental illness will be experts in their own self-management and self-care, understanding better than people who have not experienced a mental illness what triggers them and how to regain their sense of wellness.

Sarah Jane Williamson and Carl Stonier, Revised 2016
SPIRITUAL EMERGENCY OVERVIEW 1

- Individual develops and changes too quickly
  → Sense of identity/meaning is fragile
- Opens up too quickly
  → Nervous system is vulnerable
- Repressed elements surface too fast
- Strange sensations – sometimes subtle, sometimes dramatic
- Monkey-mind creates a story

INGREDIENTS

These dynamics and energies feed into the situation:

- Sub-personalities
- Repressed arousals
- Need for status
- Addictions
- Basic instincts
- Habits
- Existential angst
- Fear
- Need for meaning
- DNA inheritance
- Ancestral dynamics
- Group Karma
- Past lives
- Personal karma
- ‘Cosmic Fire/Prana’
- Spirits
- Spooks
- Archetypes
- Collective energies

SYMPTOMS

- Fear
- Anxiety
- Terror
- Sleepless
- No appetite
- Agitated
- Loss of identity
- Fragmentation of self
- Voices
- Delusions
- Mythic stories
- Monkey mind noise
- Synergies and coincidences given too much significance
- Strange sensations (electricity, energy, heat, cold, vibrations)

DENIAL

Some people avoid the full emergency and stay ‘stable’ through denial and compensatory behaviour. This can be seen in: ‘My way is the only way.’ Defensive. Fanatical. Pompous. Cultish.
What follows is a FIRST AID LIST for people in spiritual emergency. First, if you can, take a history so that you know the context.

- A comforting presence. Empathy. “You are not alone.” “This experience is not permanent and will pass.”
- Encouragement that it is a creative and positive process. “This experience is creative even if you are frightened.”
- Food.
- Rest.
- Physical movement.
- Touch from safe beings, such as animals and trees.
- Calmants – but we need to be careful here. A herbal tranquiliser.
- Stop all meditation and psychic exercises. No healers using vital energy.
- Withdraw generally from stimulation.

The most important task is to give people in crisis a positive context for their experiences and sufficient information about the process that they are going through. It is essential that they move away from the concept of disease and recognise the leading nature of their crisis. Stanislav and Christina Grof

The dark night of the soul ends in rebirth. It does not simply end in a return to the status quo. This is a spiritual truth about the soul’s journey, and it is a great consolation during the dark times. Margot Forrest

DOES THE CRISIS REQUIRE MEDICAL ATTENTION?

It is important that we able to discern when a crisis is not a passing and healthy process, but the symptom of something more serious and possibly harmful.

Adding to some evidence researched by David Lukoff, here is a list of indicators which point to the crisis as being positive and manageable. In our words:

- The individual functioned healthily before the episode
- There is no history of psychiatric care
- Intense symptoms last around 3 months or less
- There is a clearly definable trigger to the crisis
- The emergant can possess a positive exploratory attitude toward the experience
- The emergant is still able to conceptualise and organise
- The delusional communications have some mythic coherence (compared for example to a general paranoia about a conspiracy)

www.spiritualcrisisnetwork.org.uk • www.spiritualcompetency.com
SPIRITUAL EMERGENCY OVERVIEW 2

Spiritual Development may be Different from Psychological Development

The goal of psychologies: a person able to deal with life in a healthy and balanced manner; or a person who has realised their potential; or happy; or able to manage neurosis.

The goal of spiritual development: fully compassionate, fully awake and fully connected.

PSYCHOLOGICAL CHALLENGES

2. Sub-personalities: neuro-endocrinical grooves of attitude and behaviour.
3. Psychoanalytic - repressed arousals from childhood.
5. Sense of identity – more powerful than the instinct to live (suicide bombers)
6. Homeostasis – the nervous system’s function to maintain its state
7. Monkey mind – the compulsive brain function (confabulation) to interpret and tell a story with an ending and explanation. It is the source of creation myths and all our personal stories and endless chatter. It creates impatience and over-simplification. It avoids paradox and discomfort.

RESISTANCE IS NORMAL – GLUE, GRAVITY, MAGNETISM – THE YIN OF YANG

Like everything else in the cosmos we are glued together. This includes our sense of identity, attitudes and patterns of behaviour. This glue (healthily) resists change. Addiction and cravings are part of this elemental reality.

We are at a continual point of tension between Containment and Emergence

<table>
<thead>
<tr>
<th>STATE</th>
<th>CONTAIN</th>
<th>EXPAND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balanced</td>
<td>Safe, coherent and stable.</td>
<td>Movement, growth and flow.</td>
</tr>
<tr>
<td>Too much</td>
<td>Flat, sluggish and lazy; no energy for change.</td>
<td>Scattered, speedy, irritable.</td>
</tr>
<tr>
<td>Far too much</td>
<td>Melancholic and apathetic.</td>
<td>Over-stimulated, hyper, cannot sleep and burning out.</td>
</tr>
<tr>
<td>Extreme/Bipolar</td>
<td>Depression, inertia and dark night of the soul.</td>
<td>Emotionally and mentally out of control, manic, in a spiritual emergency, nervous breakdown.</td>
</tr>
</tbody>
</table>

BIRTH OF CONSCIOUSNESS

Out of this tension is born the child: new consciousness, higher self, compassionate watchfulness.

ONE BRAIN CELL SELF-MANAGEMENT

Centre • Sink into body
Witness with compassion
Diploma in Practical Spirituality & Wellness 2017

SPIRITUAL PSYCHOLOGY • BOOK LIST

* = In relation to spiritual emergency these books are particularly relevant.

Roberto Assagioli, *Psychosynthesis*
Alice Bailey, *Initiation - Human And Solar*
Alice Bailey, *Esoteric Psychology I & II*

* Emma Bragdon, *The Call of Spiritual Emergency: From Personal Crisis to Personal Transformation* and *Sourcebook for Helping People in Spiritual Emergency*
* Isabel Clarke (ed), *Psychosis and Spirituality*

Norman Doidge, *The Brain that Changes Itself – Stories of Personal Triumph from the Frontiers of Brain Science*

Jorge Noguera Ferrer, *Revisioning Transpersonal Theory: A Participatory Vision of Human Spirituality*
Eugene T. Gendlin, *Focusing: How to Open Up Your Deeper Feelings and Intuition*

Sue Gerhardt, *Why Love Matters – how affection shapes a baby’s brain*

James Griffith and Melissa Elliot Griffith, *Encountering the Sacred in Psychotherapy: How to Talk with People About Their Spiritual Lives*

* Stanislav & Christina Grof (eds), *Spiritual Emergency: When Personal Transformation Becomes A Crisis*

* Stanislav Grof, *The Stormy Search For The Self: A Guide To Personal Growth Through Transformative Crisis*

Robert Johnson, *Owning Your Own Shadow: Understanding the Dark Side of the Psyche*

Carl Jung, *The Archetypes and The Collective Unconscious*

Jean Liedloff, *The Continuum Concept*

Alexander Lowen, *Bioenergetics: The Revolutionary Therapy That Uses the Language of the Body to Heal the Problems of the Mind*

* Catherine Lucas, *In Case of Spiritual Emergency*

John E. Nelson, *Healing the Split – Integrating Spirit into Our Understanding of the Mentally Ill*

* Robert Nelson, *Helping With Spiritual Emergencies*


Jane Roberts, *The Nature of Personal Reality and The Unknown Reality I & II*

Fritz Perls and Russ Youngreen, *In and Out the Garbage Pail*


* Russell Razzaque, *Breaking Down Is Waking Up*

Wilhelm Reich, *Function of the Orgasm*

John Rowan: *Subpersonalities: The People Inside Us and The Transpersonal: Psychotherapy and Counselling*

*Daniel B. Smith, *Muses, Madmen and Prophets – Hearing Voices and the Borders of Sanity*

Alan Watts, *Psychotherapy, East and West*

Ken Wilber, *Integral Psychology: Consciousness, Spirit, Psychology, Therapy*