

'Psychosis or Spiritual Emergence? - Consideration of the Transpersonal Perspective within Psychiatry'

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*'Fool's gold exists because there is real gold'
Rumi*

As we progress into the 21st century, psychiatry is broadening its repertoire to further understand the problem of madness.

Psychosis as an altered state of consciousness (ASC)

Our deepening understanding of brain, mind and consciousness leaves us no option but to expand the neurobiology of psychosis to incorporate the concept of consciousness; its nature, levels, dimensions and dynamics, and the impact this function plays in the development of challenging, abnormal states of mind.

Psychosis has been defined as 'any one of several altered states of consciousness, transient or persistent, that prevent integration of sensory or extrasensory information into reality models accepted by the broad consensus of society, and that lead to maladaptive behaviour and social sanctions.'¹

Psychotic phenomena such as delusions and hallucinations, described and classified in ICD10² and DSM VI³, follow clinical observations, which in western society are understood as symptoms of illness. This is based on the assumption that we understand the nature of 'reality', and that there is a narrow band of 'normal' perception, outside of which there is little useful potential. That certain dramatic experiences and unusual states of mind could be more than part of a purely pathological mental state, and hold some potential for personal growth and transformation is the subject of this paper.

Spiritual emergency, consciousness and the transpersonal perspective

Observation from many disciplines, including clinical and experimental psychiatry, modern consciousness research, experiential psychotherapies, anthropological field studies, parapsychology, thanatology, comparative religions and mythology have contributed to the concept of 'spiritual emergency' a term that suggests both a crisis and an opportunity of rising to a new level of awareness or 'spiritual emergence.'

This term was first coined by Stan and Christina Grof who founded the Spiritual Emergency Network at the Esalen Institute in 1980. Its remit was to assist individuals and make referrals to therapists for people experiencing psychological difficulties associated with spiritual practices and spontaneous spiritual experiences. Grof describes a spiritual emergency:

'There exist spontaneous non-ordinary states of consciousness, (NOSC) that would in the West be seen and treated as psychosis, and treated mostly by suppressive medication. But if we use the observations from the study of non-ordinary states, and also from other spiritual traditions, they should really be treated as crises of

transformation, or crises of spiritual opening. Something that should really be supported rather than suppressed. If properly understood and properly supported, they are actually conducive to healing and transformation'.⁴

In order for psychiatry to appreciate the relevance of this perspective to the medical diagnosis and treatment of psychosis, it is necessary to move beyond our materialistic, biomechanical focus on brain function and start to expand on the concept of consciousness - that fundamental yet intangible core aspect of 'aliveness', within which is held our perceptual awareness of experience. Medicine, psychiatry and traditional psychotherapies hold the assumption that consciousness is a by-product (or epiphenomenon) of the brain and cannot persist independently of it (the productive theory of consciousness).⁵ The transmissive theory of consciousness⁵ holds that consciousness is inherent in the cosmos and is independent of our physical senses, although is mediated by them in everyday life. So the brain and the psyche can be thought of acting as a lens through which consciousness is experienced in the body.

This forms the basis of the transpersonal perspective, which received its initial articulation by thinkers and scholars in the field of psychology, Carl Jung, Robert Assagioli, Ken Wilbur and Stanislav Grof amongst others. They recognised the limitations of the field of psychology and sought insights and teachings from the spiritual traditions and certain philosophical schools of the east.

The term 'transpersonal' is used here to refer to psychological categories that transcend the normal features of ordinary ego-functioning, that is, stages of psychological growth, or consciousness, that move beyond the rational and precede the mystical. At the root of the transpersonal perspective is the idea that there is a deep level of subjectivity or pure spirit that infuses all matter and every event. A common metaphor throughout the spiritual wisdom traditions refers to this consciousness, or living spirit, (be it called Brahman, Buddha-Mind, Tao, or The Word) as having been breathed into all being at the moment of creation as a manifestation of divine nature. It is necessary for sentient life, because experience and awareness are possible only through the activating power that flows from this Source.

Transpersonal theory is a way of organising our experience of 'reality'; it is not that reality itself. It relies on the phenomenological observations of inner subjective experience and instead of merely pathologising those which do not fit into expected socio-cultural models, attempts to set them in the context of the wisdom of the world's spiritual traditions (Hinduism, Buddhism, Taoism, Judaism, Christianity, Islam and the Primal Religions) with some of the philosophical (Plato, Aristotle, Augustine, Kant, Kierkegaard) and psychological (Jungian, Humanistic, Existential) schools of the West.

Spiritual Emergence and the Transpersonal Levels

Spiritual emergence can be seen as a natural process of human development in which an individual moves beyond normal feelings and desires of the personal ego into the transpersonal realms of increasing relatedness to a Higher Power, or God. It is an acclimatisation to more subtle levels of consciousness.⁶

In *The Atman Project*⁷ Ken Wilber has described three levels of transpersonal experience, in ascending order: Subtle, Causal and Atman. At these levels people have access to a fluid creativity from a higher order of inspiration than that of the personality.

The Subtle level is that level of conscious awareness which includes extrasensory perceptions indigenous to the body, as well as those apparently separated from it such as out-of-body experiences and psychokinetic phenomena (objects moving without a physical catalyst.) The experience of this level is thought to be related to a system of energy centres in the body called chakras in Sanskrit, that are of a more subtle order than physiological organ systems, and subsequently activate a higher order of perception than that possible from our five physical senses. Experiencing awareness of dimensions beyond physical, objectified reality is often the basis for accessing a deeper, revitalised inner meaning of oneness in connection to others.

People have experienced Causal level consciousness as 'peak experiences' secondary to spiritual practice, inspired by music, taking mind-altering substances or following emotional trauma, childbirth or during intense sexual experiences. It is described as a state of perfect ecstasy, untainted by any distracting thoughts, desires or moods. The Causal level includes the awareness of Subtle and material dimensions, going beyond them to a fuller realisation of union with 'God', where there is said to be no sense of time, only eternity.

The Atman level is beyond the Causal, but including all dimensions below it. This dimension of consciousness is said to be so completely immersed in the Highest Power that nothing else exists in awareness. It is described as bringing perfect ecstasy beyond emotion. Indications of the Atman level exist in mystical religious texts where it is referred to as being beyond description.

Experience of these transpersonal realms does not necessarily precipitate a crisis. These intense intra-psychic experiences can phenomenologically appear similar to pathological psychotic states, but given the appropriate context, sensitive guidance, and opportunity to integrate the experience, individuals can reach higher levels of awareness and functioning following such an experience.

This transpersonal perspective affords us an opportunity to build a modern scientific theory of 'madness' around a radically expanded view of consciousness, and allows us to differentiate extraordinary states of consciousness that are more adaptive than the ordinary state, from alterations that restrict one's ability to function in the world.

The Transpersonal Roots of the DSM IV category *Religious or Spiritual Problem*⁸

'Religious or Spiritual problem' is a relatively new diagnostic category (Code V62.89) in the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition:

'V62.89: This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems

associated with conversion to a new faith, or questioning of other spiritual values which may not necessarily be related to an organized church or religious institution'. (American Psychiatric Association, 1994, p. 685)

The impetus for proposing this new diagnostic category came from transpersonal clinicians⁹ whose initial focus was on spiritual emergencies, following which the proposal was broadened to include religious problems. The types of religious problem it encompasses include issues surrounding loss or questioning of faith, change in denominational membership, conversion to a new faith, intensification of adherence to religious practices and orthodoxy, new religious movements and cults and issues surrounding life threatening and terminal illness.

Spiritual problems relevant to this category include spiritual emergence, mystical experiences, near death experiences, meditation and spiritual practices, psychic experiences, visionary experiences, shamanic crisis, alien encounter experiences and possession experiences. The emergence of this category has re-balanced the previous direction of psychology and psychiatry in the twentieth century, where the field of mental health largely ignored or pathologised spiritual experiences and religion. Freud promoted this view in several of his works, such as 'The Future of an Illusion'¹⁰, pathologising religion as '*a system of wishful illusions together with a disavowal of reality, such as we find nowhere else...but in a state of blissful hallucinatory confusion*'.

Freud also promoted this view in 'Civilization and Its Discontents'¹¹, where he reduced the 'oceanic experience' of mystics to 'infantile helplessness' and a 'regression to primary narcissism'. As a result, research on both psychopathology and mental health has largely ignored religion and spirituality.¹²

Surveys conducted in the United States¹³ consistently show a 'religiosity gap' between mental health professionals and the general public and patients, who in many surveys report themselves to be more highly religious and to attend church more frequently than the professional. Similarly, despite the importance of religion and spirituality in most patients' lives, adequate training is not provided by most medical education programmes to prepare doctors to deal with these issues.¹⁴ The pathologising and ignoring of religion and spirituality has resulted in clinical insensitivity towards individuals who present with religious and spiritual problems, an increasingly poor reputation for psychiatrists, inadequate research and theory and a limitation of psychiatrists' own personal development.

Respect for, and understanding of, the nature of various religious belief systems remains important for the psychiatrist.¹⁵ But this paper hopes to expand the focus beyond acknowledging just the cognitive levels of the psyche involved with religious thought and belief, to incorporate the spiritual and transpersonal dimensions of consciousness in human experience.

Differential Diagnoses: spiritual crises and psychotic disorders

'Spiritual' experience and 'psychotic' experience both inhabit the space where logical reason ceases to function, and a person's usual ego defence mechanisms have broken down. That there is a connection between spiritual

and psychotic experience is evident, though conventional thought has obscured this.¹⁶

Over forty years ago, psychiatrist and philosopher Karl Jaspers, in his seminal work *General Psychopathology*¹⁷ pronounced that the content of madness (in particular delusions) were 'un-understandable' and therefore worthy of little consideration except as a sign of an underlying primary disorder. At the start of the twenty-first century, this is still the majority opinion in mainstream psychiatry.

The anti-psychiatry movement, which began in the 1960s, claimed that psychiatric patients do not necessarily have a mental illness, but are in fact individuals who do not ascribe to the same conventional belief system, or consensus reality shared by most people in their particular culture. Adherents of this movement sometimes refer to Thomas Szasz' controversial book *The Myth of Mental Illness*.¹⁸ Apparently Szasz himself conducted a traditional psychoanalytic practice, rather than treating patients who mainstream psychiatrists would describe as having serious mental illness. The denial of mental illness as a 'myth' is not useful. It implies that those individuals detained in secure hospital environments for reasons of their own health, safety, or safety of others, and diagnosed with serious mental disorder, should not be so. It also implies that all challenging or violent behaviour, whatever the cause, should thus be contained elsewhere, presumably within the judicial system alone.

R. D. Laing was a British psychiatrist also associated with the anti-psychiatry movement, who argued that strange behaviour and seemingly confused speech of people undergoing a psychotic episode was ultimately understandable as an attempt to communicate distress, often in situations where this was not otherwise permitted. He stressed the role of society and family systems in the development of madness, seeing it as an expression of repressed negative emotion that should be valued as a cathartic and transformative experience.

In contrast, the concept of 'spiritual emergency' does not deny the seriousness of a psychotic condition in which the psyche fragments and when sometimes violent and self-destructive aspects are manifested. There is no doubt that challenging, destructive, refractory mental states exist, the expression of which creates harm, rather than healing, for the person and society at large.

Instead, this concept is intended to encourage discernment amongst mental health professionals in determining whether or not there are clues to possible personal growth from the non-ordinary experience being witnessed. Differentiating between a pathological psychotic illness or altered state of consciousness (ASC) and one which resembles a mystical state, holding potential for healthy adaptation, growth and healing, requires knowledge of the qualitative aspects of the spectrum of altered states of consciousness.

Although a detailed discussion describing this is beyond the scope of this paper, the reader is referred to Siegler, Osmond and Mann, who in their paper critiquing Laing's models of madness¹⁹ differentiate between a pathological psychotic experience and what they term 'the psychedelic experience', analogous perhaps to the mystical, extra-ordinary experiences described by saints, yogis, mystics and shamans in the spiritual literature. They do not wish to imply that the two states are entirely comparable; Nelson

¹ (pp 15-17) has described characteristics common to most psychotic ASCs, whether benign or not, and describes a continuum along which common types of madness lie on one end of a spectrum, while ASCs that include creative and mystical states lie at the other. David Lukoff ⁹ (Lesson 5) has considered in detail and referenced further work focusing on the criteria necessary for making differential diagnoses between a psychopathological presentation and an authentic spiritual state.

Certain major forms of spiritual emergency have been described which have specific features differentiating them from others. These include the shamanic crisis, the awakening of Kundalini, episodes of unitive consciousness ('peak experiences'), psychological renewal and individuation, the crisis of psychic opening, past life experiences, near death experiences and possessions states. ^{20, 6} It should be emphasised that as always with the human psyche there are no distinct boundaries. Just as Freud's individual unconscious is not truly separable from Jung's collective unconscious, so different types of intense intra-psychic experience do not fall into neat diagnostic pigeon holes, but share qualitatively similar themes.

Levels of consciousness

The idea that ASCs can be malignantly regressive and dysfunctional, or adaptively regressive preceding spiritual growth, requires an understanding of hierarchical models of consciousness described earlier in this paper. This can at first seem esoteric to Western minds, but the idea of human consciousness being layered into a hierarchy of frequency bandwidths or chakras is not new. Indeed, it features in ancient metaphysical systems which match current concepts of quantum physics.

In some Asian medical schools, the system of the seven chakras is taught as 'hard' science. This system was originally intuited from the disciplined practice of yoga and maps the progress of personal consciousness in such a way as to integrate body, mind and spirit.

Eastern medicine considers the chakras to be physical energy centres, each with a specific location in the body. They are thought to be energy vortices that draw vital life force (prana, chi) inward from a universal source, acting as interfaces between the physical and subtle realms.

Psychologically, the chakras can be related to archetypes - comprehensive themes around which life evolves and representing discrete stages of consciousness that facilitate spiritual growth throughout life. For the purpose of contrasting a psychotic regression with an adaptive one, some knowledge of stages of consciousness is important. This knowledge could be usefully applied clinically by asking the following 4 questions ¹:

1. At what level of consciousness did psychotic regression begin?
2. At what level did it end?
3. What is the highest level of consciousness ever attained by the person?
4. Do the symptoms resemble those of emerging spiritual realisation?

What is becoming clear is that ASCs ¹ or NOSCs ²¹ deserve to be reviewed by psychiatrists as states of mind that manifest important areas of the psyche that have been largely ignored by our Western models. Ken Wilbur

discusses the various schools of psychotherapy and their conflicts in the foreword to a new book on integral medicine,²² proposing that our central question should change from 'which are the best schools of psychotherapy' to 'why is it that all these school exist in the first place?' The answer, Wilbur says, is that there are various domains and dimensions of the psyche beyond our cognitive rational selves, that can and should be actively worked with. Using an expanded transpersonal model of the psyche allows us to refine our ability to categorise psychotic ASCs in ways that surpass those currently employed in the Western world, and in doing so to further refine therapeutic possibilities.

The clinical utility²³ to be gained from a diagnosis of spiritual emergence or emergency, depends upon whether therapeutic options can be tailored accordingly.

The Pathway to Recovery

For people who are experiencing an ASC related to a spiritual practice or resembling a mystical or visionary process or shamanic crisis, there are a number of relevant therapeutic strategies. Stanislav Grof, MD, and Christina Grof, founders of the Spiritual Emergence Network, describe a spiritually sensitive approach:

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 recognize the (potential) healing nature of their crisis. Whether attitudes and interactions in the narrow circle of close relatives and friends are nourishing and supportive or fearful, judgmental, and manipulative makes a considerable difference in terms of the course and outcome of the episode...

*(Therapy) should not be limited to talking and should allow full experience and direct release of emotion. It is absolutely essential to respect the healing wisdom of the transformative process, to support its natural course, and to honour and accept the entire spectrum of human experience.*²⁰

Interventions can range from support for a time-limited crisis, with possible involvement of relatives, friends, support groups, and medical persons, to intensive long-term psychotherapy. Choice of the specific intervention depends on the intensity, duration, and type of spiritual problem, as well as on the individual and their support network.

Although all psychological disturbances may have spiritual aspects to them, they are not necessarily all spiritual emergencies. In situations where someone is behaving in such an unusual way as to put him or herself, or others at risk, advice from trained mental health professionals is important. In the NHS, psychiatric emergencies are the remit of statutory mental health services, depending on the region, either a Community Mental Health Team or a Crisis Resolution Home Treatment Team, which can be accessed via a GP.

Therapeutic Interventions for Acute Crises

Therapeutic interventions for a person experiencing an adaptive ASC can include the following: (adapted from Lukoff⁹)

- Normalisation
- Grounding
- Reduction of environmental and interpersonal stimulation
- Temporary discontinuation of spiritual practices
- Encouragement of creative therapies (art, music, writing, poetry, dance)
- Creation of a therapeutic encounter/transpersonal psychotherapy
- Consideration for specific bodywork
- Evaluate for medication

Normalisation

People in the midst of intense spiritual experiences need a framework of understanding that makes sense to them. Mental health theory has so far provided little guidance in this area, and it can be the lack of understanding, guidance and support that allows such experiences to go out of control. Jung described how providing a normalizing framework helped in the following case:

I vividly recall the case of a professor who had a sudden vision and thought he was insane. He came to see me in a state of complete panic. I simply took a 400-year-old book from the shelf and showed him an old woodcut depicting his very vision. 'There's no reason for you to believe that you're insane', I said to him. 'They knew about your vision 400 years ago'.²⁴

In a similar way, Ram Dass, a spiritual teacher originally trained as a clinical psychologist, helped a person in distress by framing his experience as a Kundalini reaction. He recounted a telephone call from someone saying he thought he was going crazy. After the caller described uncontrollable tearfulness and so much energy he couldn't sleep, Ram Dass said 'Let me read you a list of symptoms, I have a Xerox. It's just mother Kundalini at work'.²⁰

Brant Cortright, PhD, describes the clinical value of educating the patient and significant others:

Education about spiritual emergency serves two primary functions. First, it gives the person a cognitive grasp of the situation, a map of the territory he or she is traversing. Having a sense of the terrain and knowing others have travelled these regions provides considerable relief in itself. Second, it changes the person's relationship to the experience. When the person (and those around him or her) shifts into seeing what is occurring as positive and helpful rather than bad and sick, this changes the person's way of relating to the experience. To know that this process is healing and growthful permits the person to turn and face the inner flow of experiences, to welcome them rather than turning away or trying to suppress them.²⁵

The patient's family and friends can play a critical role in implementing and maintaining the spiritual and grounding interventions described below. Therefore, they also need to be educated about the potential for positive transformation and how to support a person in spiritual crisis.

Grounding

Involvement with natural surroundings is the optimum homeostatic environment within which to rebalance our inner nature. A mild routine including regular gentle exercise such as walking in the fresh air or gardening should not be underestimated. Diet is an important factor, with 'heavy' foods such as grains (especially whole grains), beans, dairy products, and meat being recommended as opposed to just fruits and salads. Sugar and stimulants like caffeine or alcohol are also not advised and fasting should be avoided.

Reduction of environmental and interpersonal stimulation

The person undergoing a spiritual emergency, often both hyper-aroused and hyper-sensitive, needs to be shielded from the psychic stimulation of the everyday world, which is usually experienced as painful and interfering with the inner process. The therapist needs to work with the patient to determine the specific people and situations that exacerbate the dysfunctional aspects of the spiritual emergency. The sanctuary of a retreat centre is ideal, an environment often in stark contrast to a psychiatric ward.

Temporary discontinuation of spiritual practices

Meditation has triggered many reported spiritual emergencies. Meditation teachers who hold intensive retreats are familiar with this form, and have developed strategies for managing such occurrences. Yoga, Qi Gong, and other spiritual practices can also be triggers. Usually teachers advise ceasing the practice temporarily. It can be reintroduced as the person becomes more stable.

Encouragement of creative therapies (art, music, writing, poetry, dance)

The creative arts can help a person express and work through their inner experience. The language of symbol and metaphor can help integrate that which can never be fully verbalized.

Creation of a therapeutic container/ transpersonal psychotherapy

A variety of alternative therapeutic environments to acute psychiatric wards have been developed and trialled, with positive results which have been extensively reviewed.²⁶ The Soteria Project was one of these, designed as a drug free treatment environment, which was as successful as anti-psychotic drug treatment in reducing psychotic symptoms over the course of 6 weeks.²⁷ John Perry, MD, founded 'Diabysis' in 1974, a residential treatment centre in San Francisco for working with people in visionary psychotic states. He emphasized that when a person's psyche is energized and activated, what he or she needs is contact with a person who empathizes, who actively encourages the process, who provides a loving appreciation of the qualities emerging through the process, and who facilitates the process rather than attempting to halt or interfere with it.

Brant Cortright highlights the qualities required of the therapist:

*In spiritual emergency, the personal presence of the therapist is key. Although some people are able to sail these waters successfully by themselves, for many people the presence of one or more wise compassionate guides on this journey can be of enormous help.*²⁵

Of importance therefore is the need to have a therapist or guide who knows the transpersonal territory, an aspect of the psyche that psychiatrists are not formally educated about.

Consideration for specific bodywork

Bodywork describes a range of therapeutic techniques, usually but not always involving physical touch, focused on relieving blockages and tension within the body, hence assisting the healing process, for example, biodynamic massage, acupuncture or chiropractic. Energetic bodywork includes subtle techniques intended to work on the subtle body* and human energy field, concepts from Eastern medicine that also include meridians and chakras.

Experience of ASCs will likely involve dissolution of ego structure, and as psychic structures reorganise, the physical body remains the essential vehicle in which to integrate the entire experience. Consideration of the body is central to the healthy reintegration of mind and spirit, and good bodywork can be key in this process.

Evaluate for medication

Some practitioners, such as John Perry have argued that medication only inhibits a person's ability to concentrate on inner work, as it mutes the psychic energy needed to sustain the effort to move the process forward. When medication is used to simply repress the inner process, it becomes frozen in an unfinished state. Suppression can impede the potential for a complete working through to a point of resolution.

Sometimes the process is so intense that the person is overwhelmed and becomes very anxious. That person could benefit from slowing down the process. Bruce Victor, a psychiatrist and psychopharmacologist, uses low doses of tranquillising or antipsychotic medication to alleviate some of the most distressing feelings and allow the person to better assimilate the experience.

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It is a common occult teaching that man consists of a number of different subtle bodies or vehicles of consciousness. We have for example the Neoplatonic-Hermetic idea of the body: vital spirit (pneuma), soul (psyche), and Divine intellect (nous); the Indian five-self doctrine of the Taittiriya Upanishad: physical or "food" self, life-force (prana) self, mental (manas) self, consciousness-intellect (vijñana) self, and bliss (ananda) self; the corresponding Advaita Vedantic idea of the five koshas ("sheaths"); the Theosophical idea, inspired by Advaita, of seven Principles of self; and Rudolph Steiner's ontology of physical body, etheric body, astral body, and Ego or body, soul, and spirit, in large measure based on Theosophy; and the orctic/endothymic and noetic/egoic faculties of the "strata-psychology" school that developed earlier in the 20th century.

The resolution of this seeming contradiction lies in the assessment of whether the presence of the debilitating state serves the function of psychological growth. Although the experience of pain, whether psychological or physical, can be a powerful motivator for personal change, its persistence beyond a certain point can retard it.

Some psychiatrists with sensitivity to the spiritual emergency process have discussed their methods at conferences. Their approach is to prescribe dosages of medication that dampen down the inner process so the patient can continue work on an outpatient basis instead of an inpatient basis. Medication practices have already been influenced by new understandings of spiritual emergencies. For example, Bruce Greyson, MD ²⁸ reports that persons in intensive care units (ICU) who report out-of-body experiences and encounters with angels are no longer seen as having 'ICU psychoses' requiring treatment with anti-psychotic medication.

Together with consideration of the level of distress and the growth potential is a person's level of support and the degree of any risk involved.

If someone is in a situation which can support his/her involvement in intensive inner process, for example, in a communal setting, such as a spiritual retreat centre, it is possible to go much deeper while being cared for physically and supported in working through the crisis. However, people living in less supportive environments often do need to maintain themselves at a higher level of functioning, otherwise they risk vulnerability to hospitalisation, loss of their livelihood, living situation, and other essentials. A risk assessment must also be part of an assessment for medication and must take into account the spiritual emergency patient's support system. Euphoric feelings of oneness whilst in a potentially adaptive altered state of consciousness will still be a risk to that person and to others if driving a car at high speed down a motorway.

Ideally, any use of medication should be with the full understanding and consent of the person, who should be an active participant in the decision-making.

The ability to safely handle potential risk (i.e. to self or others) in someone who does not have the capacity to absorb reasonable advice or consent to medication, is not possible outside of statutory mental health services. Psychiatrists are trained to assess risk and capacity and act accordingly, both in the best interests of the patient and society, neither of which should ever be compromised.

The Future

Although scientific technology has furthered the success of some medical specialities, of concern for Psychiatry is the singular lack of resolution of depression, anger and violence amongst our patients, indeed in society as a whole. Despite the fact that modern science has all the knowledge necessary to eliminate most diseases, combat poverty and starvation, and generate enough safe and renewable energy, we remain living in an often violent, disparate world.

The problems we are facing now are not merely economic, political or technological in nature. They are reflections of the emotional, moral and spiritual state of contemporary humanity ²⁰. One of the few hopeful and encouraging developments in the world today is the renaissance of interest in

ancient spiritual traditions and the mystical quest. People who have had powerful transformative experiences and have succeeded in applying them to everyday life show very distinct changes in their values. Perhaps this development holds potential for all of us, since it represents a movement away from destructive and self-destructive personality characteristics and the emergence of values that foster individual and collective survival.

As psychiatrists, perhaps we can look at the significant problems in society that have become our remit and understand them in a broader context, both appreciating the depths and dimensions of the psyche and potentially harnessing some good by working experientially with it. Working directly with altered states of consciousness in a therapeutic context is not within the remit of this paper. It will require a re-evaluation of our basic social assumptions about what is pathological, what is healing and what is likely to be progressive. In the longer term this may require institutional change in the structure and type of care that is provided.

In 1999, The Royal College of Psychiatrists (UK) founded a Special Interest Group in Spirituality and Psychiatry, to serve two needs: the creation of an enabling forum where psychiatrists could meet and explore the relevance of spirituality to mental healthcare, and to acknowledge the fact that user-led surveys had indicated that they felt the lack of spiritual dimension within psychiatry, and to work towards alleviating this. (<http://www.rcpsych.ac.uk/college/sig/spirit>) The recent development of the Spiritual Crisis Network in the UK also indicates renewed interest and motivation. (<http://www.spiritualcrisisnetwork.org.uk/>)

In Conclusion

Psychiatry must meet the challenge to broaden its repertoire. We can now include recent findings in medical and neuroscientific research, together with the ancient wisdom of the perennial philosophy, and consider the implication that has for understanding an expanded cartography of the psyche, which includes the transpersonal dimension.

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