

The Healing Potential of Anomalous Perceptual Experiences

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If the Doors of Perception were cleansed, everything would appear to Man as it is, infinite. For Man has closed himself up, till he sees all things thro' narrow chinks of his cavern.

William Blake, *The Marriage of Heaven and Hell* (1790)

Introduction

In this short paper, I want to outline the nature of anomalous perceptions, challenge some assumptions about what we mean by reality and briefly illustrate how we may work with them.

Anomalous perceptions undoubtedly can happen due to neuropathology — for example, Delirium Tremens, Parkinson's disease, dementia, temporal lobe epilepsy and so on, can give rise to them. However, psychiatry has shown a disturbing tendency to pathologize *all* such experiences. We see this at its most pervasive in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) and the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10; World Health Organisation, 1992) is close behind. We live in a diagnostic climate predisposed to classify any anomalous experience as indicative of illness.

It is only too easy to start thinking of antipsychotics as treatment for a specific disease process; likewise antidepressants. At a public event, I heard a young woman begin with the words, 'I have had depression for ten years!' — I was tempted privately to say to her, 'That's a long time not to allow yourself to feel angry'.

Yet psychodynamic approaches also share the tendency to over-pathologize. Just about everything can be explained with reference to repression, projection, denial and so on, and many psychoanalysts have their fingers crossed that neuroscience will validate Sigmund Freud's dream of a scientific psychology (cf. Freud, 1895).

An understanding of psychopathology is necessary to the work we do, especially in severe mental illness. The problem arises when, thanks to the ego, we over-identify with our favoured point of view. Then we mistake the part for the whole and so we close the door on other perspectives, not least the transpersonal.

What is reality?

I'll hope to keep the door open with this quotation from Kahlil Gibran (1920, p. 45).

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A fish said to another fish, 'Above this sea of ours there is another sea, with creatures swimming in it — and they live there, even as we live here.' The fish replied, 'Pure fancy! When you know that everything that leaves our sea by even an inch, and stays out of it, dies. What proof have you of other lives in other seas?'

When we wear glasses, especially when they afford a clear focus, we soon forget we are wearing them. So it is with the consensus view of reality. We see with the eyes of a science that began with Newton and Descartes over 300 years ago, one that tells me that I, the subject, am separate from the object of my study. This science treats the material world as 'reality', while regarding consciousness as epiphenomenal — something produced by the brain. Being entirely subjective, consciousness is beyond the scope of empirical science and so, like the proverbial elephant in the room, it gets ignored. At best, it is conceded to be useful for studying 'real' things.

Also beyond the reach of science are values. Some scientists will say there is a value, namely truth. Such truth is limited, since the discoveries of science all derive from measuring instruments made out of matter. What follows, naturally, is the science of material realism, founded on the material world of the five senses.

The epistemology of science has no place for qualia such as beauty, love, sorrow, joy, compassion, forgiveness and wholeness of being, yet all these are just as 'real' as anything out there in the sensorial world. Nevertheless, in this age of scientism,² a person's sorrow is turned into an object-like 'thing' called 'depression', fear of life becomes a condition called 'generalised anxiety disorder', hearing voices becomes a symptom of an illness called 'psychosis', and the sighting of a recently departed loved one is classed as pseudo-hallucination.

Largely ignored by received wisdom — and by psychiatry too — are the mysterious discoveries of quantum mechanics, entirely at odds with material realism. The very concept of objectivity is challenged, for quantum entanglement means that everything is relational. Far from being a personal possession, consciousness is envisaged as a non-local unified field in which we are all immersed. Mind and matter are conceived of as a tangled hierarchy, two sides of one coin. The physicist David Bohm (1980, p.174) put it like this:

Ultimately, the entire universe (with all its particles, including those constituting human beings, their laboratories, observing instruments, etc.) has to be understood as a single undivided whole, in which analysis into separately and independently existent parts has no fundamental status.

Aside from any religious belief a person may hold, the transpersonal perspective³ situates our lives here within a far greater whole. As Hamlet famously said, 'There are more things in heaven and earth, Horatio, than are dreamt of in your philosophy'.

² The view that empirical science constitutes the most authoritative worldview to the extent that other perspectives are devalued or altogether excluded.

³ The transpersonal has been defined as 'experiences in which the sense of identity or self extends beyond (*trans*) the individual or personal to encompass wider aspects of humankind, life, psyche or cosmos' — see Walsh and Vaughan (1993: 203).

Anomalous perceptions

The only true voyage ... would be not to visit strange lands but to possess other eyes

(Marcel Proust, 1923, p. 657)

Anomalous perceptions that meet the ICD-10 criteria for hallucination⁴ have traditionally been counted among Schneider's first rank symptoms (auditory hallucinations, thought broadcast, thought insertion, thought withdrawal, and delusional perception: symptoms suggestive of, but not indicative of, schizophrenia). Nevertheless, they do not in themselves signify mental illness, as Gordon Claridge's work on schizotypy has clearly shown (see, e.g., Claridge, 1997). Given that ten per cent of the general population will have such a perception during their lifetime, the experience is clearly too common to be indicative of pathology.

Anomalous perceptions can be linked to stress, fatigue, sensory deprivation, intoxication and drugs but also arise in good health. They occur in out-of-body states, lucid dreaming, mediumship, prayer and meditation and in bereavement (14 per cent, see Rees, 1971). They can be frightening, as sometimes during a spiritual crisis, or blissful, as with an epiphany. They may involve any of the senses (namely: auditory, sense of presence, olfactory, tactile, gustatory and somatic¹) but the two I will single out here are apparitional, and what is known as 'presence', which William James (1890, pp. 322-3) described as follows:

'It would appear to be an extremely definite and positive state of mind, coupled with a belief in the reality of its object quite as strong as any direct sensation ever gives. And yet no sensation seems to be connected with it at all'.

Four clinical examples of anomalous perception

An after-death apparition

Gareth was referred to me by his general practitioner for depression. He had cared for his mother during her illness with cancer, and after she died he was burdened with the memory of her suffering. When Gareth came for the second session, he said something had happened that had been a shock. One night, soon after lying down, he had clearly seen his mother standing at the end of the bed. When he rubbed his eyes and looked again, she had gone. He thought he must be going out of his mind.

Rather than just reassuring Gareth, I asked him to recall how his mother had looked. He said it was strange but she was smiling. Had she spoken? Gareth replied that nothing was said but he felt she was somehow telling him she was well and he shouldn't worry. I put to Gareth that this visit by his mother was not only nothing to be afraid of but also that it could be of great value and a comfort to him. Gareth said he was so relieved to think his mother, wherever she was, could feel well and happy again and his mood began to lift the same day.

⁴ Any percept-like experience which (a) occurs in the absence of an appropriate stimulus, (b) has the full force or impact of the corresponding actual (real) perception, and (c) is not amenable to direct and voluntary control by the experiencer.

Soul reunion

Joan came to see me a year after the death of her husband Ted. They had been together forty years and her loss left her grief stricken. She continually felt Ted's presence around the house and yet the awareness brought only pain.

I asked Joan if she thought there could be an afterlife. Yes, she thought there might be, but how could that help her now? Would she like to try to make contact with Ted in a way that might bring her peace of mind? At my suggestion, Joan shut her eyes, relaxed, and was encouraged to see if she could 'find' Ted wherever he might be. After a couple of minutes, a faint smile played on her lips. I asked her what she saw. She replied that she could see Ted in his cricket whites playing cricket looking fit and well. I said that it seemed Ted was enjoying a game of heavenly cricket! Joan's smile widened and she added that cricket had been Ted's great passion. Then a look of sadness passed over her face. I asked if she would like to speak with Ted and she nodded, so I suggested she walk up to him and see what might happen. After a pause, Joan said that she was now next to Ted and that he had put his arm around her. What was he saying? He was saying, 'Don't worry; everything is going to be all right'. I asked Joan to look around her. Was anyone else there? Then she saw her deceased sister and parents, smiling and waving to her.

Being able to see death not as an ending but as a transition helped Joan resume life with hope and expectation.

Is suicide the end?

Heather came to see me complaining of feeling depressed and '*not herself*'. Taking an antidepressant had helped but she was still '*not herself*'. I was struck by her use of the phrase.

Going into Heather's background, I learned that shortly before her symptoms started, a close friend had taken her life in Heather's home, having been staying there while my patient was away on holiday.

Remembering how she had twice said she was '*not herself*', I asked Heather if she had the feeling of '*someone else*' when she came back home. She replied that she hadn't wanted to say that in case I thought she was mad, but every time she went into the house, she had the physical sensation of her friend being right there in the room with her.

Taking this at face value, I asked Heather if she would like me to invite the spirit of her deceased friend to the consultation to see if we could find out more about what was going on. Heather was willing, so I asked her to close her eyes, tune in to her friend and try letting her friend speak through her.

Her friend '*came through*' and went on to express deep regret at having taken her life. Suicide had solved nothing. She remained unhappy, lonely, and seeking comfort. I explained that staying on was having a bad effect on my patient, and was not helping herself either. She apologised. '*If only I had known*', she said, '*what I know now. I was facing the biggest challenge of my life and I went and messed it up. I feel even worse than I did before*'. I said I was sure other opportunities would be given her. She was very relieved to hear this and we talked more about her hopes for another chance at life. When she agreed that she was ready

to move on, I asked her to look for 'the light'. She exclaimed, 'Yes, I can see it!', and left at once. Immediately, Heather felt the burden of oppression lift from her and it did not return.

A soul narrative

Helen came to see me troubled by the sensed presence of a woman calling out to her in distress. Through deep relaxation, I was able to make contact with the woman, who gave her name as Marianne and this is the story she told.

Marianne had lived several centuries ago. Her mother had died in childbirth and the baby was left on the doorstep of a local convent. She was taken in, the convent became her home and Marianne grew to love the Mother Superior.

One day some drunken militia broke into the convent. Marianne was told to go and hide. The nuns were all raped and killed. Afterwards, Marianne ran weeping into the nearby woods. Overwhelmed with guilt at not saving her beloved Mother Superior, she hanged herself. At once she found herself back at the scene of the massacre. From that time on, she wandered alone in a state of despair until she found herself attracted to my patient Helen, and 'moved in'.

The immediate task was to release Marianne into the light. As soon as she crossed over, the first person to greet her was Mother Superior. Marianne wept and asked for forgiveness. Mother Superior embraced her, saying, 'You have nothing to blame yourself for'. Marianne answered, 'But how can I repay all you did for me?' Mother Superior replied, 'You are repaying me now by letting me be the first to greet you'. Then they left together.

Marianne never troubled Helen again. The therapeutic effect on my patient was profound, for it also addressed a lifelong concern of hers — fearing to love for fear of loss. In a letter some months later, Helen wrote that both she and Marianne had been released from what she called 'the trap of abandonment'.

In conclusion

These case studies illustrate the therapeutic benefit of accepting and working with the *existential reality* of our patients' experiences and beliefs rather than assuming that such anomalous perceptions denote pathology. My personal preference is to see our lives as part of a greater, spiritual whole that encompasses and transcends material reality. There are provisos to working in this way. First, there must be diagnostic acumen when deciding on a transpersonal approach. Second, there are ethical considerations here, and it is important to be in tune with the patient's preferences and beliefs. Third, no interpretation should be imposed — let water find its own level. Last and not least, the spiritual must always be grounded in the psychological.

We need to recognise when chaplaincy is best placed to help the troubled soul. Yet psychiatrists who are open to the spiritual dimension — whether or not working transpersonally — will have the reward of touching the souls of their patients, just as their patients will likewise touch them, and both will feel the better for it.

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