A MULTIPLE-CASE STUDY
EXPLORING PERSONAL PARADIGM SHIFTS THROUGHOUT THE PSYCHOTIC
PROCESS FROM ONSET TO FULL RECOVERY

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Approval of the Dissertation

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This dissertation by Paris Williams has been approved by the committee members below, who recommend it be accepted by the faculty of Saybrook University in partial fulfillment of requirements for the degree of

Doctor of Philosophy in Psychology

Dissertation Committee:

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Doris Bersing, Ph.D., Chair       Date

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Thomas Greening, Ph.D.       Date

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Kirk Schneider, Ph.D.       Date
The aim of the dissertation was to explore how the personal paradigms of those who have recovered from long-term psychosis changed throughout the psychotic process, from onset to full recovery. My hope was that such an inquiry might provide us with useful information regarding what takes place during the psychotic process at the most fundamental (existential) level of experience, and that perhaps this information might offer some guidelines and perhaps even a more or less universal map that can be of service to others who are still struggling with psychosis.

Qualitative multiple-case study methodology was used to inquire into the experience of six participants who had suffered from long-term psychosis and who are now considered to be fully recovered. Data collection consisted of an initial questionnaire, one live interview of a minimum of one hour, and three follow-up email interviews. A quantitative instrument was also used (the Posttraumatic Growth Inventory) to supplement the qualitative data. Data analysis consisted of developing individual and cross case themes for each of six prefigured categories of experience: description of the anomalous experiences, the onset and deepening of psychosis, recovery, lasting personal paradigm shifts, lasting benefits, and lasting harms. After exhaustive analysis of the data,
a theoretical model was formulated that assisted in discussing the implications of the data.

The results revealed that all six participants had striking parallels in their experiences with regard to all six categories of experience. The most central implications that emerged from the findings with regard to all participants are as follows: an overwhelming existential threat to the self apparently played an important role in the onset of psychosis; the psychotic process was likely initiated by the psyche as an attempt to regain equilibrium in the face of this threat; recovery was primarily assisted by reconnecting with hope, meaning, a sense of agency, and the cultivation of healthy relationships; psychiatry generally caused significantly more harm than benefit in the process of recovery; and the successful resolution of the psychotic process apparently involved a profound reorganization of the self along with significantly more lasting benefits than harms.
Acknowledgments

I want to express my gratitude to the three members of my dissertation committee for their support through this very challenging yet rewarding process. I thank Kirk Schneider, Ph.D., for providing a penetrating existential perspective that has been cultivated throughout many years of deep contemplation, and for his willingness to push me and ask the hard questions. I thank Tom Greening, Ph.D., for his willingness to serve as my primary mentor throughout my years of graduate study, for the great wisdom that he has shared with generosity, humility, and humor, and for providing an impeccable role model as a leader in this field who is willing to challenge the status quo and not allow the rest of us to forget that compassionate and honest service to our clients comes first and foremost. I especially want to express my deep gratitude for the chair of my committee, Doris Bersing, Ph.D., for her unwavering support in every step of this challenging process, and for providing an inspiring example of someone who can balance challenging family circumstances with a noble commitment to students, clients, and the progression of the mental health care field, and to do all of this while not losing sight of the humanity and the needs of all involved.

I also want to express my gratitude to my wife, Toni, who remained by my side during this often arduous journey, and who was ever ready to serve as a sounding board and provide a grounded reference point as I grappled with the many complex, controversial, and abstract concepts that arose within this work.
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Introduction

During much of the past century, there has been the general assumption, both in mainstream psychology and psychiatry and among the general public, that schizophrenia and other long-term psychotic disorders are degenerative and offer very little hope of full recovery. Over the past several decades, however, numerous longitudinal studies (Calabreze & Corrigan, 2005; Harrow & Jobe, 2007; Hopper, Harrison, Janca & Satorius, 2007; Siebert, 1999) as well as a plethora of first-person accounts (for example, Bassman, 2007; Beers, 1981; Dorman, 2003; Greenberg, 1964; Modrow, 2003) have brought attention to the fact that not only do some people recover from schizophrenia but also recovery is surprisingly common. In fact, it has been observed that many of those who recover do not simply return to pre-episodic functioning, but they find that their levels of functioning and wellbeing have improved significantly beyond those of their pre-episodic condition (Arieti, 1978; Perry, 1999; Siebert, 1999; Tooth, Kalyanasundaram, Glover & Momenzadah, 2003). One would expect that those who have experienced psychosis and successfully reintegrated back into society would have much to offer those who are still struggling in the midst of it. The purpose of this study, then, is to explore this possibility by inquiring into the subjective experience of six participants who have experienced long-term psychosis and are now recovered.
**Terminology**

Following is a list of definitions for terms that are pertinent to this topic but whose definitions are often ambiguous and/or controversial. By offering these definitions, I am not attempting to disregard the controversies surrounding them, but am merely attempting to posit definitions that offer maximum encompassment of the literature in order to facilitate discussion and research related to this topic.

- **Anomalous experience**: A subjective experience (typically either a sensory experience or a belief) that is considered invalid within the framework of consensus reality (according to the particular individual’s society).

- **Psychotic experience**: An anomalous experience that causes significant distress.

- **Psychosis**: An ongoing condition in which psychotic experiences are predominant.

- **Long-term psychosis**: A psychotic episode that lasts for one month or longer; or a series of psychotic episodes, the total duration of which is longer than one month.

- **Recovery**: The condition of experiencing a general lessening of the distressing aspect(s) of one’s anomalous experiences.

- **Recovered (or full recovery)**: The condition of having achieved a homeodynamic balance in which the overall distress (and not necessarily the anomaly) of one’s subjective experiences is the same or less than that which preceded the psychosis.

Below, I explain these terms in more detail, and I also include the definitions of several other closely related terms.

**Positivism and Constructivism**

The topic of schizophrenia is usually addressed from within the positivistic epistemology, which maintains as its core principle the assumption that “physical and social reality is independent of those who observe it” (Gall, Gall & Borg, 2007, p. 16). With regard to the topic of schizophrenia, then, positivism places primary emphasis on *normal vs. abnormal* and carries the assumption that some of us perceive a “true”
objective reality while others’ perceptions are merely “false” and/or “crazy.” A number of scholars have suggested, however, that positivism has serious limitations, especially when it comes to understanding mental phenomena (Bentz & Shapiro, 1998).

Positivism emphasizes objectivity, and its primary method of inquiry—the scientific method—requires objective observation. Mental phenomena, however, are highly subjective, and arguably cannot be directly observed by anyone other than the subject. Therefore, while there are certainly many types of inquiry for which positivism would be an appropriate epistemological framework, the direct study of mental phenomena is arguably not one of them. Constructivism is an alternative epistemology that assigns much more validity to subjective phenomena than positivism, and therefore it is likely to offer us a much more facilitative theoretical framework from which to explore schizophrenia, psychosis, and recovery. Constructivism suggests that concepts and even perceptions ultimately do not have any purely objective value but are “constructed” directly out of our subjective experience (Creswell, 2007). The implication here is that if there is an objective reality, it cannot ultimately be known. Therefore, from this perspective, regardless of whether we label someone as schizophrenic or psychotic, or as sane, we all perceive a world that is distorted to some degree through our own cognitive and social constructs.

From this perspective, then, we see that it is very difficult, if not impossible, to determine the ultimate validity of two of the major defining symptoms of psychotic disorders—delusions and hallucinations. We can dispute whether or not, or to what degree, an individual’s beliefs or perceptions are in accord with the belief system of a particular culture or society (often referred to as consensus reality), but an external
observer standing outside the framework of another’s experience is simply not in the position to make absolute judgments regarding validity. Some suggest, for example, that such experiences may represent some confusion between two valid realms (for example, between the archetypal and the mundane, the conscious and the unconscious, or between other valid realms of experience; Clarke, 2001; Mindell, 2008, Perry, 1999; Tobert, 2001). While most of the research on this topic is grounded in a positivistic framework, it is important to keep in mind that positivism, like any other epistemological framework, is ultimately based on a foundation of assumptions about the nature of the world rather than on objective truth.

**The Medical Model**

Kraepelin, a positivistic thinker, was the first to clearly articulate the system of assumptions that underlies the field of biological psychiatry and to formally assert that schizophrenia and other mental disorders are products of brain pathology (Bentall, 2003). In 1886, the year of his first appointment as a professor of psychiatry, Kraepelin began to shape his ideas on psychiatric classification. Based on his clinical work and theoretical speculation, he concluded that psychiatric disorders, like physical illnesses, are discrete entities with distinct physiological etiologies. He is perhaps best known for labeling one particular cluster of symptoms *dementia praecox* (meaning literally “senility of the young”), which eventually evolved into today’s diagnostic label, *schizophrenia* (meaning literally “split mind”). Though Kraepelin failed to identify any form of physical pathology associated with dementia praecox or any of the other diagnostic labels he coined, he remained confident that such pathology would one day be found (Bentall, 2003).
As the field of psychiatry (still generally considered to be the highest authority in the field of mental health in the West, especially regarding the psychotic disorders such as schizophrenia) gained power, its allegiance to Kraepelin’s model grew. In 1978, Klerman, considering himself to be a member of the *neoKraepelinian movement*, clearly articulated this model in the following manifesto:

1. Psychiatry is a branch of medicine.
2. Psychiatry should use modern scientific methodologies and base its practice on scientific knowledge.
3. Psychiatry treats people who are sick and who require treatment for mental illness.
4. There is a boundary between the normal and the sick.
5. There are discrete mental illnesses. Mental illnesses are not myths. There is not one, but many mental illnesses. It is the task of scientific psychiatry, as of other medical specialties, to investigate the causes, diagnosis and treatment of mental illnesses.
6. The focus of psychiatric physicians should be particularly on the biological aspects of mental illness.
7. There should be an explicit and intentional concern with diagnosis and classification.
8. Diagnostic criteria should be codified, and a legitimate and valued area of research should be to validate such criteria by various techniques. Further, departments of psychiatry in medical schools should teach these criteria and not depreciate them, as has been the case for many years.
9. In research efforts directed at improving the reliability and validity of diagnosis and classification, statistical techniques should be utilized.

(As quoted in Bentall, 2003, p. 59)

Although these principles are rarely explicated as clearly as they are here, it is evident that they are still very much a part of the dominant paradigm in the mental health field today, a paradigm that is often referred to simply as the *medical model*. When researching long-term psychotic disorders, it is important to acknowledge that most of the assumptions in the West that underlie the concepts used for these disorders (such as psychosis, schizophrenia, *schizoaffective disorder*, etc.) come directly from this model (American Psychiatric Association [APA], 2010; American Psychological Association, 2008).
Schizophrenia

Since the time of Kraepelin, schizophrenia has remained the hallmark diagnosis for long-term psychosis. Clinicians use a set of criteria based on the expressed and observed perceptions, beliefs, and behavior of an individual (the same protocol used for diagnosing any of the other so-called “mental illnesses”). This set of criteria is outlined within the Diagnostic and Statistical Manual (DSM), which is produced by the American Psychiatric Association. Following is a summary of the criteria for schizophrenia listed in the most recent edition of the DSM: the DSM-IV-TR (APA, 2000a):

Characteristic Symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if effectively treated):

1. delusions
2. hallucinations
3. disorganized speech (e.g., frequent derailment or incoherence)
4. grossly disorganized or catatonic behavior
5. negative symptoms, i.e., affective flattening, alogia, avolition

Note: Only one [of these] symptoms is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person’s behavior or thoughts, or two or more voices conversing with each other. (p. 153)

Several qualifications are given in addition to these characteristic symptoms, including the existence of significant social and/or occupational dysfunction, and the existence of “signs of the disturbance” (APA, 2000a, p. 154) persisting for at least six months, even though the actual characteristic symptom(s) only need to last for a minimum of one month. Those suffering from long-term psychotic conditions are sometimes assigned different diagnoses—primarily schizoaffective disorder and severe cases of bipolar disorder—depending upon the level of corresponding affective disturbance and cyclical nature.
From a constructivistic stance, it is clear that these criteria require highly subjective judgment on the part of the clinician, and in fact, the diagnosis of schizophrenia is highly controversial. Despite over a century of intensive research, no biological markers or physiological tests that can be used to diagnose schizophrenia have been found (APA, 2003), its etiology continues to be uncertain (APA, 2010), and we do not even have clear evidence that the concept of schizophrenia is a valid construct (British Psychological Society [BPS], 2000). However, the act of diagnosis continues unhindered by these serious problems.

**Psychosis**

Essentially, schizophrenia is considered to be long-term psychosis; however, the concept of psychosis, like the concept of schizophrenia, does not have a clear-cut, mutually agreed upon definition, and the definitions that have been posited are highly controversial. Highlighting the ambiguity of the term psychosis, even the DSM-IV-TR (APA, 2000b), admits that “the term *psychosis* has historically received a number of definitions, none of which has achieved universal acceptance” (p. 297). The DSM then goes on to give its own extremely vague definition, one that it never further clarifies: “the term psychosis refers to the presence of certain symptoms. The specific constellation of symptoms to which the term refers varies to some extent across the diagnostic categories” (p. 297). For the purpose of discussing recovery from psychosis, the DSM’s definition is not particularly helpful. Unless we are able to arrive at a working definition for psychosis, however, any discussion of recovering from it is essentially meaningless. I propose that a helpful way to view psychosis involves first making the distinction between anomalous experiences that are distressing and those that are not.
**Anomalous experiences.** Within the mainstream positivistic epistemology, the content and form of the subjective experience of psychosis are generally described as being delusions and/or hallucinations (APA, 2000b). In accordance with positivistic thinking, there is the assumption that these experiences are not valid because they do not conform to consensus reality, and so the ultimate goal should be to bring the individual’s experiences back into alignment with consensus reality as quickly as possible. However, from a constructivistic perspective, consensus reality does not necessarily correspond to some objective truth, and indeed may be vastly different from one culture to another (Moghaddam, Taylor, & Wright, 1993). Therefore, I find it more useful to define subjective experiences that fall outside of consensus reality as simply *anomalous experiences*, rather than assuming that they are psychotic.

**Psychotic experiences.** Just as we can cite numerous examples of subjective mental experiences that are considered normal and yet could be considered distressing and limiting (e.g., bereavement, worry, stage fright), there are also numerous examples of subjective mental experiences that do not conform to consensus reality (e.g., anomalous beliefs and perceptions) and yet clearly do not result in distress and/or limitation. For example, there are many people who hear voices but are not at all distressed by them, and some even find them to be helpful (Heery, 1989; Romme, Escher, Dillon, Corstens, & Morris, 2009; Watkins, 2008). Ordinarily, based on the criteria found within the DSM (APA, 2000b), such experiences would be considered psychotic based purely upon the degree of their dissonance with consensus reality, but if such experiences do not cause harm to oneself or others, then what is the benefit of labeling them as such? Doing so
leads to the difficult and sometimes impossible task of trying to determine whose beliefs and perceptions are closer to so-called objective reality.

I believe that it would be much more useful to determine the degree to which an individual’s anomalous experiences interfere with his or her ability to experience satisfying relationships, meet his or her basic needs, maintain a sense of wellbeing, and support the wellbeing of those with whom he or she interacts (in other words, the degree of distress and/or limitation, which I will refer to collectively as simply distress).

Considering, then, that both anomalous and so-called normal mental experiences may or may not cause distress, I suggest that a useful definition for psychotic experiences is “anomalous mental experiences that cause significant distress.” There are two aspects of the way I am using the term distress here that are important to emphasize: (1) ultimately, distress is subjective—no one except for the individual experiencing distress is capable of determining what is and what is not distressing for that individual; and (2) the distress I am referring to here may either arise directly from the anomalous experience itself (e.g., fear arising directly from an experience of auditory hallucinations) or arise from behavior that was a direct result of the anomalous experience. A hypothetical example of this is the case of someone believing that he or she can fly and then happily jumping out of a ten-story window. The anomalous experience itself (believing one can fly) may not cause distress, but the resulting behavior almost certainly will (if not to the individual, then certainly to the observers and/or any loved ones left behind).

**Long-term psychosis.** For the sake of this research, I am simply defining long-term psychosis as any episode of psychosis that lasts for a minimum of one month (drawing from the DSM-IV’s criteria for schizophrenia) or a series of psychotic episodes
the total of which is at least a month. This therefore may include cases which have been diagnosed as schizophrenia, schizoaffective disorder, and severe cases of bipolar disorder.

**Recovery**

Having made a distinction between distressing and non-distressing anomalous experiences, I propose that *recovery* must refer to the abatement of the distressing aspects of anomalous experiences. In other words, it is distress that one is recovering from, not necessarily anomaly. Therefore, someone is recovering when the distress associated with these experiences is diminishing, regardless of whether or not the anomalous aspects of these experiences are diminishing.

In the life sciences, it is common to think of living organisms as existing in a state of homeostasis, which is an organism’s resistance to change and its ability to maintain a stable internal environment. Mainstream psychology and psychiatry evidently draw from this model when attempting to return a psychotic individual to a state that is as close to his or her pre-psychotic state as possible. Rubik (2002), however, suggested that it is actually more accurate to conceive of organisms as living in a homeodynamic state, as opposed to a homeostatic one. The term *homeodynamics* suggests that “once a new stressor is encountered, the organism never returns to its previous dynamic state, but establishes a new dynamic balance appropriate to this newly integrated experience” (Rubik, 2002, p. 707). I believe it is important to acknowledge this understanding when defining recovery, and so I have incorporated it into my working definition for recovery: “The condition of having achieved a homeodynamic balance in which the overall distress
(and not necessarily the anomaly) of one’s subjective experiences is the same or less than that which preceded the psychosis.”
Literature Review:  
Introduction

As I set the intention to conduct a thorough literature review of recovery from long-term psychosis, it immediately became apparent that this is an extremely complex topic. I have come across countless theories regarding etiology, course, and even the essential nature of psychosis, and strong, often passionate, debate between the various proponents. In an attempt, then, to present a relatively coherent and comprehensive literature review, I have chosen to divide the literature review into three sections, with each section setting the stage for the following section and further narrowing down this complex web of information to culminate in my research focus.
Literature Review Part I: 
Schizophrenia and Recovery

A Critique of the Brain Disease Theory of Schizophrenia

In modern Western society, the large majority of those diagnosed with schizophrenia receive their primary care from psychiatrists who subscribe to the theory that schizophrenia and other psychotic disorders are caused by diseases of the brain (i.e., the medical model; APA, 2010; National Institute of Mental Health [NIMH], 2010a; Hopper et al., 2007). Unfortunately for these patients, the prognosis for their condition when viewed through this theoretical lens is extremely poor. According to this theory, schizophrenia is a brain disease not unlike Alzheimer’s or Parkinson’s, and just as there has never been a documented case of someone making a full recovery from either of these (Siebert, 1999), so it is generally assumed that one can never fully recover from schizophrenia, at least not without some biological cure still awaiting discovery. Therefore, when discussing the topic of recovery from schizophrenia, it is important to look closely at the validity of this belief system. The belief in this theory is predominant within the Western mental health field, with the most influential leaders of this field widely promoting it and citing research which purports to support it (APA, 2010; NIMH, 2010a) in spite of their admission that the specific etiology of schizophrenia is still undetermined (NIMH, 2010; Satcher, 1999). I will now look in turn at each of the most widely held theories related to schizophrenia that fall under the umbrella of the medical model, and evaluate the research which is claimed to support them.

The biochemical imbalance theory. The first hypothesis suggesting that schizophrenia may be caused by chemical means was posited over 50 years ago. In 1938, the Swiss chemist Albert Hoffman accidentally ingested a very small amount of a
substance he had synthesized from the fungus ergot (Hoffman, 1979). The substance was lysergic acid diethylamide (LSD), and the result was a hallucinogenic state apparently quite similar to many described psychotic states. This discovery led some researchers to speculate that perhaps schizophrenia is caused by a self-created (endogenous) substance (Wooley & Shaw, 1954). In 1962, it was thought that a breakthrough had occurred in substantiating this theory when a pink spot was discovered on the chromatography paper used to test schizophrenia patients’ urine. The initial belief was that the pink spot indicated the speculated endogenous hallucinogenic substance; however, it was soon discovered that this spot was correlated with the ingestion of a combination of foods commonly consumed by psychiatric patients, and support for the “endogenous hallucinogen” theory soon faded away (Stabenau, Creveling, & Daly, 1970).

Soon after the endogenous substance theory had begun to fade away, the first dopamine imbalance hypothesis was posited. In 1951, the French naval surgeon Henry Laborit accidentally stumbled upon a drug which had such a powerful numbing effect on his surgical patients that they needed almost no anesthetic (Healy, 2008). Laborit also noticed that the drug seemed to put his patients into a strange daze, in which they seemed completely indifferent to anything going on around them, and yet they maintained enough cognizance to answer questions. One of his colleagues noticed that this effect was very similar to that seen in lobotomized patients, and he suggested it may be useful in psychiatry. Much research was soon conducted with this drug, soon to be named chlorpromazine, and two important features were soon discovered about it: (1) it reduces a number of psychotic symptoms, at least in the short term, and (2) it blocks dopamine receptors (as did all of the other antipsychotic drugs that became available at that time;
Carlsson & Lindqvist, 1963). These findings soon led to the hypothesis that schizophrenia is caused by an excess of dopamine within the individual’s brain (Healy, 2008).

This new hypothesis led to a vast amount of research which seemed to support it very well. First, trials demonstrated a correlation between the amount of chlorpromazine given and the reduction of psychotic symptoms in the short term (McKenna, 1994). Second, trials conducted in the early 1970s showed that drugs such as amphetamines and L-DOPA (used to treat Parkinson’s disease), which are known to increase dopamine in the brain, sometimes lead to psychotic states in otherwise normal people (Abi-Dargham, 2005). And third, patients diagnosed with schizophrenia have been found to be generally more vulnerable to psychotic effects as a result of the dopamine-increasing drugs (Bentall, 2003). The result of these and other similar studies has been a continuation of the dopamine hypothesis to the present time, with ongoing controversies over the details, such as which dopaminergic neural pathways are most affected and whether or not imbalances exist in entirely different pathways (e.g., serotonergic pathways; Abi-Dargham, 2005).

As research has continued into this area, however, serious doubts about the dopamine hypothesis have arisen. For example, although it is known that an individual’s D2 dopamine receptors (the type of receptors most affected by typical antipsychotic drugs) are completely blocked within hours of consuming a sufficient dose of an antipsychotic drug, the actual antipsychotic effects often do not become apparent for up to several weeks (Bentall, 2004). If psychotic symptoms are the direct result of too much
dopamine, it is argued, then why do we not see a more immediate abatement of these symptoms as soon as the dopamine levels have been effectively reduced?

Another finding that challenged the validity of the dopamine hypothesis came about during the search for increased D2 dopamine receptor levels in the brains of schizophrenic patients using postmortem search and PET scans of live patients. Initially, the studies seemed to indicate support for the theory by demonstrating that a higher level of dopamine receptors existed in these patients. Lee and Seeman (1980) were among the first researchers to validate this finding. However, Lee and Seeman and others suggested that the dopamine receptors of these patients may have increased as an adaptation response to the antipsychotic drug treatment itself (i.e., these neurons may have attempted to increase their number of dopamine receptors in an attempt to compensate for the dopamine-inhibiting action of the antipsychotics). Subsequently, several different research teams, using animal and postmortem studies, all confirmed that when the effects of antipsychotics on dopamine receptors was factored in, there was no significant difference in dopamine receptor levels between the patients and healthy controls (Burt, Creese, & Snyder, 1977; Kornhuber et al., 1989; Mackay, 1982).

These multiple challenges to the validity of the dopamine hypothesis have led a number of researchers to lose heart in it altogether. John Kane, a well-known researcher at the Long Island Jewish Medical Center, was one of these, confessing that “a simple dopaminergic excess model of schizophrenia is no longer credible. . . . Even Carlsson, who first advanced the hypothesis, [has] concluded that there is ‘no good evidence for any perturbation of the dopamine function in schizophrenia’” (as quoted in Whitaker, 2002, p. 198).
Hyman, neuroscientist, provost of Harvard University, and ex-director of NIMH, summarized over 40 years of research on the mechanism underlying the effects of antipsychotic drugs. One of the main conclusions he arrived at was that the use of antipsychotics actually *creates*, rather than corrects, a biochemical imbalance within the brain. Prior to treatment, those diagnosed with schizophrenia have no known biochemical imbalances within the functioning of their neurons, but once they are placed on antipsychotics, the brain goes through a dramatic modification that results in abnormal neurotransmission:

“The chronicity and strength of the perturbations [caused by these drugs] drive these homeostatic mechanisms [i.e., adaptations of the brain in response to the drugs] until cellular signaling [i.e., neurotransmission] achieves a new adapted state, which may be qualitatively as well as quantitatively different from the normal state” (Hyman & Nestler, 1996, p. 161)

As support for the dopamine hypothesis has waned, many researchers have begun to look for other possible biochemical imbalances (for example, with the neurotransmitters GABA, glutamate, and serotonin), but numerous peer reviews have found that the research does not substantiate these hypotheses either (Read, 2004). So after 50 years of intensive research, the biochemical imbalance theory still has not been substantiated.

**Abnormalities in brain structure.** Another popular generator of hypotheses has been the idea that abnormalities in brain structure may be the cause, or at least indicative, of schizophrenia. The first attempts to study the postmortem brains of psychiatric patients were conducted by Kraepelin, the original founder of the concept of schizophrenia (which he termed *dementia praecox*), around the turn of the twentieth century. He asserted that “partial damage to, or destruction of, cells of the cerebral cortex must
probably occur . . . which mostly brings in its wake a singular, permanent impairment of the inner life” (as quoted in Bentall, 2004, pp. 310-11). In the end, however, his search did not result in any significant findings.

It was not until about seventy years later, in the early 1970s, with the invention of CT scanning, that an apparent breakthrough in this quest had finally arrived. CT scans allow views of cross-sectional slices through the brains of living patients, and in 1976, Johnstone and her colleagues published the first report showing significantly enlarged lateral ventricles in the brains of patients who had been diagnosed with schizophrenia, something that strongly implied atrophy of the cerebral cortex and perhaps other regions of the brain (Johnstone, Frith, Crow, & Owens, 1988). Numerous other studies have since come out (using both CT scanners and, arriving in the 1980s, the more technologically advanced MRI scanners), nearly all of which have replicated these findings. Wright et al. (2000) conducted a meta-analysis of 58 studies with 1,588 schizophrenia patients and found that the mean total ventricular volume of these patients was 126% that of the control group. Similar studies continue to accumulate today, with the most recent studies being able to distinguish with very precise detail exactly which areas of the brain are experiencing atrophy. For example, in one of the most recent studies in this area, Gaser, Nenadic, Buchsbaum, Hazlett, and Buchsbaum (2004) were able to isolate shrinkage of the thalamus, “especially of medial nuclei and the adjacent striatum and insular cortex, [and therefore concluded that these] appear to be important contributors to ventricular enlargement in schizophrenia” (p. 154). The impressive collection of studies corroborating the correlation between ventricle enlargement and the diagnosis of schizophrenia makes this one of the most consistent findings of a neurobiological
correlate with schizophrenia. On the surface, all of this evidence appears to provide substantial support for the hypothesis that schizophrenia is the product of a brain disease; but upon closer inspection, this support begins to unravel.

The first finding that challenged the validity of the brain structure abnormality hypothesis came with the realization that numerous factors have been found to lead to ventricle enlargement. Among these are depression, alcoholism, early childhood trauma (Read, 2004), water retention, pregnancy (Woodruff & Lewis, 1996), advancing age, educational achievement, social class, ethnicity, and head size (Bentall, 2004). Perhaps the most relevant factor that has been demonstrated to cause ventricular enlargement (and other significant brain damage) is the use of antipsychotic medication, and virtually all of the research that discovered increased ventricular volume in those diagnosed with schizophrenia did not control for this important factor (Read, 2004; Siebert, 1999). Therefore, it is likely that many and perhaps most of the participants of these studies had been taking antipsychotics, and thus likely had some degree of ventricular enlargement as a result of antipsychotic use when their brains were evaluated. It was also discovered that ventricle size can actually fluctuate quite rapidly within even healthy individuals, leading to varying results even within the same individual (Bentall, 2004).

Furthermore, the majority of those diagnosed with schizophrenia do not show any obvious brain abnormality at all. Lewine (1998) found that “there is no brain abnormality in schizophrenia that characterizes more than 20-33% of any given sample. The brains of the majority of individuals with schizophrenia are normal as far as researchers can tell at present” (p. 499); of course these findings include those who are exposed to other factors such as antipsychotic medications. Conversely, it is common to find healthy individuals
who have no schizophrenic symptoms and yet have brain abnormalities similar to those sometimes found in schizophrenics (Siebert, 1999).

Finally, it is important to keep in mind that unusual modifications of the brain are not always indicative of disease. Numerous studies have shown that various experiences modify our brains all of the time. For example, the volume of the posterior hippocampus has been shown to increase in London taxi drivers as they memorize the streets of the city (Maguire et al., 2000), while the hippocampus and corpus callosum have been shown to atrophy as a result of post-traumatic stress following warfare (Bremner, Randall, Scott, & Bronen, 1995) or sexual abuse (Andersen et al., 2008).

When we look at the sum total of all of this research relating to brain abnormality, we find another hypothesis that has so far failed to be validated. First, we realize that there are many factors that can lead to ventricular enlargement, combined with the fact that most people who are diagnosed with schizophrenia have also been exposed to one or more of these other factors (early childhood trauma, depression, alcoholism, and especially the use of antipsychotic medication). When we add to this the fact that the majority of patients diagnosed with schizophrenia do not show brain abnormalities at all (even when exposed to these other significant factors) while a number of healthy subjects do, the support for this hypothesis becomes highly questionable.

**Heredity.** So after looking closely at the research that has been purported to support the hypotheses that brain abnormalities (both biochemical and structural) cause schizophrenia, we find that these hypotheses still have not been validated. But what about the issue of heredity in schizophrenia? Many have suggested that schizophrenia is a disease with a strong genetic component. This is a fairly complex topic, and to look at it
critically requires that we break it down into several parts. We must look at the validity of research that reports a genetic basis of schizophrenia, and we must also look critically at the assumption that finding a genetic link for schizophrenia confirms that schizophrenia is a disease.

Most mainstream psychiatric and mental health authorities refer to the heredity of schizophrenia as a well-established fact. The NIMH, for example, said:

Scientists have long known that schizophrenia runs in families. It occurs in 1 percent of the general population but is seen in 10 percent of people with a first-degree relative (a parent, brother, or sister) with the disorder. People who have second-degree relatives (aunts, uncles, grandparents, or cousins) with the disease also develop schizophrenia more often than the general population. The identical twin of a person with schizophrenia is most at risk, with a 40 to 65 percent chance of developing the disorder. (NIMH, 2010a)

While these are some highly significant figures, and they are said from a very high authority in the field, some scholars in the field have challenged their validity (Breggin, 2008a; Joseph, 2004; Read, 2004). Joseph (2004) is one of the most active researchers in the field regarding the topic of genetics and schizophrenia, having published over thirty articles in peer-reviewed journals and two books on this and closely related topics. He pointed out that the basis for all of the current genetic research that attempts to isolate genes for schizophrenia (more on this later) is contingent upon the validity of only a small handful of twin and adoption studies, all of which he has concluded had significant validity problems.

**Twin studies.** The logic behind the twin studies is quite straightforward: if reared-together monozygotic (identical) twins have a significantly higher rate of concordance than reared-together dizygotic (fraternal) twins, then, according to the logic behind these studies, the genetic basis for schizophrenia should be confirmed. This is
because the monozygotic twins share 100% of their genes, while the dizygotic twins share an average of about 50% (the same as any two siblings). All such twin studies (published after 1963, when the research methods were considered much more sound), when pooled together, showed that the monozygotic twins have a concordance rate of 22.4%, while the dizygotic twins have a concordance rate of 4.6% (Joseph, 2004). These are much lower rates than those cited above by the NIMH, but they are still significant. The monozygotic twins have a concordance rate that is four to five times higher than that of dizygotic twins, and few would question the significance of this. However, these figures are significant only if the validity of the studies is significant, and Joseph argued that they are not. He listed numerous methodological problems with these studies, including

1. lack of an adequate and consistent definition of schizophrenia; 2. non-blinded diagnoses, often made by investigators strongly devoted to the genetic position; 3. diagnoses made on the basis of sketchy information; 4. inadequate or biased methods of zygosity determination (that is, whether twins are monozygotic or dizygotic); 5. unnecessary age-correction formulas; 6. non-representative sample populations; and 7. lack of adequate descriptions of methods. (p. 69)

However, even considering all of these methodological problems, Joseph conceded that the concordance rate is clearly higher for the monozygotic twins, just as it is for most psychological and biological traits. Where the fatal problem to this type of study lies, he claims, is in the assumption that the two types of twins share similar environments. He argued that this assumption is not at all true—monozygotic twins are treated much more similarly, encounter more “identity confusion,” and encounter significantly more similar environments than dizygotic twins. Because of these significant differences, Joseph argued that the difference in concordance rates between the two types of twins can be explained purely by environmental differences alone:
“There is no reason to accept that monozygotic-dizygotic comparisons measure anything more than the *environmental* differences distinguishing the two types of twins [author’s emphasis]” (2004, p. 69).

A second method of twin studies consists of single-case reports of monozygotic twins that have been raised apart. However, because of small sample sizes, there have not been any systematic reared-apart twin studies for schizophrenia or any other psychiatric condition (Joseph, 2002).

**Adoption studies.** The second research methodology that has played a major role in establishing the theory of schizophrenia as a genetic disorder is the adoption study. To date, there have been only seven major adoption studies on schizophrenia (Joseph, 2004). In three of the studies, the main goal of the study was to research the outcomes of adoptees whose biological parent(s) had been diagnosed with schizophrenia, comparing them with a control group (adoptees whose biological parent(s) had *not* been diagnosed with schizophrenia; Heston, 1966; Rosenthal, 1971; Tienari et al., 1987). In the fourth study, adoptees with schizophrenic biological parents who had been adopted to normal parents were compared with adoptees with normal biological parents who had been adopted by parents with schizophrenia (Wender, Rosenthal, Kety, Schulsinger, & Welner, 1974). The three remaining studies (which are separate parts of one expanded study) began with adoptees who had been diagnosed with schizophrenia, and then involved the search for their biological parents to find the percentage of them who had also been so diagnosed (again, a control group was used for comparison; Kety, Wender, Jacobsen, & Ingraham, 1994). In all of these studies, the researchers concluded that they found evidence that supported a genetic factor for schizophrenia (Heston, 1966; Kety et
al., 1994; Rosenthal, 1971; Tienari et al., 1987; Wender et al., 1974). In spite of these apparently robust findings, however, several critical analyses have been performed on all of these that question the methods and conclusions (Joseph, 2004; Modrow, 2003).

One particularly potent criticism is that “most of these studies would not have found statistically significant differences without greatly expanding the definition of schizophrenia to include non-psychotic ‘schizophrenia spectrum disorders’” (Joseph, 2004, p. 73). For example, Kety et al.’s (1968) first study found zero cases of chronic schizophrenia within the first-degree relatives of those diagnosed with schizophrenia, and Rosenthal’s study (1971) found just one of the 76 offspring adopted away was later diagnosed with schizophrenia. When Joseph (2004) narrowed the definition to the DSM diagnosis for schizophrenia and recalculated the results, he found that only two of the seven studies show significant differences between the experimental groups and the control groups, and he argued that even these two have significant validity issues from one or more of the other factors mentioned above.

A second significant criticism regards the problem of selective placement of the adoptees (Joseph, 2004). Joseph pointed out that in all three regions and time periods in which these studies were conducted, compulsory eugenic sterilization of people diagnosed with schizophrenia and other “mental disorders” was in effect, meaning that most of the offspring of such parents would have been labeled as offspring of schizophrenics, and this would have certainly influenced the placement of these infants. Joseph (2004) declared, “One can conclude that the most qualified potential adoptive parents, who were usually informed of ‘deviance’ in the adoptee’s family background, would not have selected children with a biological family history of mental disorders” (p.
Unfortunately, few of the studies explicitly mentioned this factor, and therefore this criticism, while certainly noteworthy, is speculative.

**The search for genetic linkage.** My review of the criticism of the schizophrenia heredity research so far has consisted primarily of just one researcher’s work: Joseph (2002, 2004), since he is one of the few who has thoroughly critiqued this literature. However, many of the researchers who are clearly in favor of the genetic position have also expressed doubts and concerns. Contemporary research into the heredity of schizophrenia has moved away from twin and adoption studies and towards efforts to locate the specific genes themselves within DNA, but so far no such genes have been found. Crow (2007), one of the most widely published researchers in this area, said in one of the most recent reviews of genetic research that was published in the *American Journal of Psychiatry*, that “recent meta-analyses have not identified consistent sites of genetic linkage. The three largest studies of schizophrenia fail to agree on a single locus . . . and there is no replicable support for any of the current candidate genes” (p. 13). Williams and his large team of genetic researchers (Williams et al., 1999) admitted, “Our results suggest that common genes of major effect . . . are unlikely to exist for schizophrenia” (p. 1729). Most leaders of the field are losing hope that they will ever find a single gene that is linked to schizophrenia and are instead hoping that they will have more success by looking for many associated genes of small effect, each of which increases susceptibility for schizophrenia (Crow, 2007). Delisi (2000), another schizophrenia genetic researcher, concluded that “psychiatric genetics appears to be at a crossroads or crisis” (p. 190). Joseph (2004) replied to Delisi’s comment, saying, “The
‘crisis’ facing psychiatric genetics is that investigators are looking for genes that probably do not exist” (p. 78).

**Does heredity imply a medical disease?** Both the research that purports to support the genetic theory of schizophrenia and the criticism against it are significantly limited. Of the three major categories of research typically cited to support the brain disease theory of schizophrenia—biochemical imbalance, abnormal brain structure theory, and heredity—it is arguably heredity which maintains the highest likelihood of receiving some significant validation. Yet, heredity is arguably the factor which is least likely to be indicative of disease. Those who support the theory that schizophrenia is the product of a brain disease often argue that if we do someday find significant evidence of a genetic link to schizophrenia, then this will confirm that it is in fact a disease, but is this really so?

There are many psychological characteristics that are genetically influenced but that are clearly not diseases. One obvious example is intelligence, which is estimated to have genetic influence that is at least as high as that reported in the schizophrenia studies (Dickins & Flynn, 2001), and yet it is doubtful that anyone would consider genius a physical disease. Another example is shyness, which has also been shown to have a genetic basis (Kagan, Reznick, & Snidman, 1988). But would anyone really consider shyness a disease? As Modrow (2003) pointed out, “the concept of disease refers neither to social undesirability nor to heritability, but to cellular pathology: histopathological lesions and pathophysiological processes” (p. 288). Evidently, it is because the symptoms that we associate with the diagnosis of schizophrenia are generally considered so unusual and undesirable that we are so quick to make the assumption that any evidence of its
heritability would imply disease; yet, considering that psychological traits with heritable components such as shyness and intelligence are clearly not diseases, the assumption that schizophrenia can be proven to be a brain disease based merely on heritability is seriously flawed. If we ever do demonstrate with certainty that schizophrenia has a significant genetic component, this alone would not validate the claim that schizophrenia is a brain disease.

**Correlation is not causation.** A final important question to ask when examining the validity of the brain disease hypothesis is how valid are the assumptions which gave rise to it. One of the most important assumptions in this regard is that when and if it becomes established that there is some clear correlation between some anomalous feature of the brain and the characteristics we label as schizophrenia, then it will also be established that it is this brain anomaly that is the causative factor of schizophrenic experiences. However, this assumption involves the confusion between correlation and causation. As already mentioned, there is substantial evidence that environmental factors can lead to both immediate and permanent changes to the brain (both chemically and structurally; Andersen et al., 2008; Bremner et al., 1995; Maguire et al., 2000). There is also evidence of high correlations between the experience of childhood trauma (especially those that resulted in intense feelings of loneliness and terror) and the later onset of schizophrenia (Karon, 2003). We also know that just as injuries and lesions in the brain can affect mental functions, so can consciously directed mental functions lead to direct changes in the brain. Siegel (2007), a pioneering neuroscience researcher at UCLA, said:

> We can say that brain and mind correlate their functions, but we actually don’t know the exact ways in which brain activity and mind function mutually create
each other. It is too simplistic to say merely that the “brain creates the mind” as we now know that the mind can activate the brain...the mind can directly stimulate brain firing and ultimately change the structural connections in the brain. (p. 24)

The brain disease hypothesis has relied heavily upon the assumption that correlations between schizophrenia and brain anomalies (when and if they are found) implies that the brain must be the primary causative agent, and yet our understanding that the mind and the environment can affect the brain, and that all three of these may cause psychotic experiences, has effectively weakened the validity of this assumption.

The brain disease theory continues to be unsubstantiated. So, what exactly have we learned from all of this research? Of the thousands of research studies conducted over more than a hundred years, what can actually be said about this phenomenon we call schizophrenia? When we look to the highest authorities on the matter, we find confusing mixed messages. For example, the NIMH (2010a), on its Schizophrenia home page, proclaims confidently that “schizophrenia is a chronic, severe, and disabling brain disorder” (paragraph 1), a statement you find on nearly every major page or publication they have put out on the topic; and yet if you spend a little more time looking through their literature, you will find that they admit that “the causes of schizophrenia are still unknown” (NIMH, 2010b, paragraph 1). Similarly, the APA (2010) also confidently proclaims that “schizophrenia is a chronic brain disorder” (paragraph 1), but then they acknowledge on the very same page that “scientists do not yet know which factors produce the illness” (paragraph 10), and that “the origin of schizophrenia has not been identified” (para. 10). The strong bias towards the brain disease theory is clearly evident in the literature of these and other similar organizations, and yet the message still comes through that we still do not know the cause of schizophrenia. Even the U.S. Surgeon
General (Satcher, 1999) began his report on the etiology of schizophrenia with the words, “The cause of schizophrenia has not yet been determined” (paragraph 1). It would appear, then, than it is simply not appropriate to claim with such confidence that schizophrenia is a brain disorder.

Considering the vast amount of research on the subject, it is truly impressive how few solid conclusions we have been able to draw about schizophrenia, and perhaps it is this lack of conclusiveness that is the most revealing thing of all. Many researchers (for example, Bentall, 2003, 2004; Breeding, 2008; Breggin, 2008a; Mosher, 2008; Read, 2004; Siebert, 1999; Szasz, 2008; Whitaker, 2010) have concluded that, ironically, the lack of significant evidence in all of this research provides us with highly significant evidence that schizophrenia is most likely not a disease of the brain. These researchers have pointed out the flaw in the assumption that so-called abnormal behavior and perceptions must imply disease. Breggin (2008a), for example, offered the following analogy:

To claim that an irrational or emotionally distressed state, however extreme, in itself amounts to impaired brain function is simply false. An analogy to television sets and computers may illustrate why this is so. If a TV program or Internet site is offensive or irrational, it does not indicate that anything is wrong with the electronics of the television set or the hardware of the computer. It makes no sense to attribute the bad programming or the offending Internet site to bad wiring. Similarly, a person can be very disturbed psychologically, without any corresponding defect in the wiring of the brain. (p. 18)

When we consider the enormity of the effort to substantiate the brain disease theory of schizophrenia combined with the continued lack of support for it, it is difficult not to draw the same conclusion as Breggin (2008a) and the others mentioned above: The brain disease hypothesis must be seriously flawed.
Is Schizophrenia a Valid Construct?

Thus, in spite of the pervasiveness of the myths held within our society, there is actually very little evidence that schizophrenia is the result of a biological disease. There are many researchers, however, who have taken this argument one step further, suggesting that schizophrenia may not even be a valid construct. There are three major elements of this argument: (1) all of the various major psychotic disorders may simply be variations of one phenomenon; (2) there may be no clear boundaries between psychosis itself and what we think of as sanity; and (3) it may simply be impossible to ever arrive at universally agreed upon definitions of schizophrenia, psychosis, or even of “madness” itself.

Using a continuum instead of categories. The British Psychological Society (the BPS, Great Britain’s counterpart to the American Psychological Association; 2000), in its official report summarizing their understanding of “mental illness” and “psychotic experiences,” concluded that the research suggests that there are not actually clear boundaries between the major psychotic disorders (schizophrenia, schizoaffective disorder, and bipolar disorder):

[One] way of examining the validity of diagnostic categories involves using statistical techniques to investigate whether people’s psychotic experiences actually do cluster together in the way predicted by the diagnostic approach. The results of this research have not generally supported the validity of distinct diagnostic categories. For example, the correlation amongst psychotic symptoms has been found to be no greater than if the symptoms are put together randomly. Similarly, cluster analysis—a statistical technique for assigning people to groups according to particular characteristics—has shown that the majority of psychiatric patients would not be assigned to any recognisable [sic] diagnostic group. Statistical techniques have also highlighted the extensive overlap between those diagnosed with schizophrenia and those diagnosed as having major affective disorder. (p. 17)
The BPS has suggested, in other words, that the various psychotic disorders are most likely not discrete entities at all (physiological, psychological, or otherwise), but may more appropriately be classified as variations of one phenomenon, a phenomenon that many have suggested we refer to simply as *madness* (Bentall, 2003).

**Seeing madness and sanity as a continuum.** The BPS (2000) has taken these conclusions one step further, suggesting that “mental health and ‘mental illness’...shade into each other and are not separate categories” (p. 18). In other words, they suggest that not only are various psychotic disorders best understood as merely representing different points on a continuum of a single phenomenon, but that sanity and madness themselves are also best understood as merely different points along a single continuum. They cite evidence suggesting that psychotic experiences are merely extreme expressions of more ordinary traits found within the general population.

**Schizophrenia and madness as essentially contested topics.** After conducting a thorough grounded theory study using participants who have been diagnosed with schizophrenia, Geekie and Read (2009) (both researchers who also have extensive clinical experience working with this population) came to the conclusion that the most accurate way to define schizophrenia is as an *essentially contested topic*. What they mean by this is that “madness is, quite simply, something about which we argue the meaning of, inevitably, and interminably” (p. 143). In other words, arriving at a universally agreed upon definition of schizophrenia in particular, or madness in general, is simply not possible:

Even in mainstream psychiatric textbooks, the literature on schizophrenia is characterized by a confusing plurality of theories, each competing for dominance… We see then that there is consensus about one thing: that
schizophrenia has been, and continues to be, subject to a wide range of explanations. (p. 138)

Geekie and Read suggested that a major reason that this debate is still as heated and unresolved as ever is that the terms schizophrenia, psychosis, and madness have been mistakenly perceived as pointing to some objectively verifiable entity, when they may merely be placeholders “in an ongoing debate that we have about who and what these terms actually refer to” (p. 143). In other words, Geekie and Read suggested that these terms do not refer to objective entities but rather to subjectively and socially constructed categories, and they are therefore just as prone to pluralistic interpretations and flux as are other subjective and social phenomena.

The BPS (2000) has recognized this problem to some degree and has attempted to mitigate it by suggesting that the term schizophrenia be dropped altogether and replaced with the more inclusive term psychosis. However, Geekie and Read (2009) made the point that the term psychosis has been and continues to be subject to the same problems that have plagued the term schizophrenia in this regard, so they have argued that it would be more helpful to acknowledge that madness is an essentially contested topic, to honor the role of pluralism when addressing it, and to devote most of our resources to determining what actually contributes to the wellbeing of those who are suffering from this phenomenon, regardless of what we choose to call it.

The Longitudinal Research on Recovery

So, considering that the etiology of schizophrenia is still unknown and that even the validity of the very concept of schizophrenia is questionable, how do we explore the topic of recovery from schizophrenia? Whether or not schizophrenia is a valid concept, it is clearly evident that many people do suffer from distressing anomalous experiences,
and when such suffering becomes relatively chronic, these individuals will most likely be diagnosed with schizophrenia. (As mentioned earlier, depending on various details of their symptoms, especially the type and extent of affective distress vs. cognitive symptoms, such individuals may alternatively be diagnosed with one of the other major psychotic disorders—schizoaffective disorder and bipolar disorder.) Therefore, when we look at the research on recovery from schizophrenia, while we cannot say with any certainty that there is any biological disease from which these participants are recovering, we can say with some degree of confidence that these participants have been suffering from long-term distressing anomalous experiences, and we can explore the issue of recovery from within this context.

While there continues to be the widespread belief in our society that people diagnosed with schizophrenia generally do not recover (Whitaker, 2010), the actual research tells a very different story. Table 1 provides a list of all of the major longitudinal recovery studies of at least 15 years duration that I was able to find.

Going into the details of all of these studies would be quite lengthy and fall outside the scope of this paper; however, I will go into more detail with the more pertinent of these studies in a later section. For now, there are several key points that are worth mentioning:

First, each study uses somewhat different criteria for determining what is meant by *significantly improved* and *fully recovered*, and some have slightly different terminology to represent these classifications, yet they all essentially agree that fully recovered refers to participants being asymptomatic and self-sufficient in meeting their needs, both socially and financially, for some specified period of time.
<table>
<thead>
<tr>
<th>Name of Study</th>
<th>n</th>
<th>Average Follow-up (years)</th>
<th>Recovered or Significantly Improved</th>
<th>Fully Recovered</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Burgholzli study (Bleuler, 1974)</td>
<td>208</td>
<td>23</td>
<td>First-episode: 66% Entire cohort: 53%</td>
<td>First-episode: 23% Entire cohort: 20%</td>
</tr>
<tr>
<td>The Iowa 500 study (Tsuang &amp; Winokur, 1975)</td>
<td>186</td>
<td>35</td>
<td>46%</td>
<td>20%</td>
</tr>
<tr>
<td>The Bonn Study (Huber et al., 1975)</td>
<td>502</td>
<td>22.4</td>
<td>65%</td>
<td>22%</td>
</tr>
<tr>
<td>Lausanne study (Ciompi, 1980)</td>
<td>289</td>
<td>37</td>
<td>49%</td>
<td>27%</td>
</tr>
<tr>
<td>Chestnut Lodge study (McGlashan et al., 1984a, 1984b)</td>
<td>446</td>
<td>15</td>
<td>36%</td>
<td>not mentioned</td>
</tr>
<tr>
<td>The Japanese study (Ogawa et al., 1987)</td>
<td>105</td>
<td>21-27</td>
<td>77%</td>
<td>31%</td>
</tr>
<tr>
<td>The Vermont study (Harding et al., 1987)</td>
<td>269</td>
<td>32</td>
<td>68%</td>
<td>45%</td>
</tr>
<tr>
<td>The Cologne study (Marneros et al., 1989)</td>
<td>148</td>
<td>25</td>
<td>58%</td>
<td>7%</td>
</tr>
<tr>
<td>The Maine sample (DeSisto et al., 1995)</td>
<td>269</td>
<td>36</td>
<td>49%</td>
<td>not mentioned</td>
</tr>
<tr>
<td>The Dutch study (Wiersma et al., 1998)</td>
<td>82</td>
<td>15</td>
<td>77%</td>
<td>27%</td>
</tr>
</tbody>
</table>
Table 1 (continued)

<table>
<thead>
<tr>
<th>Name of Study</th>
<th>n</th>
<th>Average Follow-up (years)</th>
<th>Recovered or Significantly Improved</th>
<th>Fully Recovered</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO International Study of Schizophrenia --incidence cohort (Hopper et al., 2007)</td>
<td>502</td>
<td>15</td>
<td>67%</td>
<td>48%</td>
</tr>
<tr>
<td>WHO International Study of Schizophrenia --prevalence cohort (Hopper et al., 2007)</td>
<td>142</td>
<td>25</td>
<td>63%</td>
<td>54%</td>
</tr>
<tr>
<td>The Chicago Study (Harrow &amp; Jobe, 2007)</td>
<td>64</td>
<td>15</td>
<td>On antipsychotics: 51%</td>
<td>On antipsychotics: 5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Off antipsychotics: 84%</td>
<td>Off antipsychotics: 40%</td>
</tr>
</tbody>
</table>

Second, the finding that recovery rates are quite high is surprisingly robust. The authors of the largest such series of studies, the World Health Organization (WHO) studies, have concluded that the “overarching message [is that] schizophrenia is largely an episodic disorder with rather favorable outcome for a significant proportion of those afflicted” (Hopper et al., 2007, p. 37). Note also that while there is significant variation in the results of these studies, there is a general pattern that is somewhat consistent across these studies: Generally one half to two thirds of the participants in these studies have significantly improved over the long term, generally about a quarter of the participants are rated as having fully recovered, and generally less than a quarter remain permanently disabled. It is also interesting to note that many of the participants in these studies who have recovered were those who were considered to be the most profoundly disturbed
(Siebert, 1999). Returning to the brain disease hypothesis for schizophrenia, it is illuminating to compare the high recovery rate for schizophrenia with the recovery rate for well-established diseases of the brain such as Parkinson’s, Alzheimer’s, or multiple sclerosis: There is no documented evidence of even a single individual making a full recovery from any of these well-established brain diseases (Siebert, 1999).

Finally, several of these studies have provided data that allow us to directly compare the outcomes for participants using the Western standard treatment for schizophrenia (typically the use of antipsychotics) with the outcomes for participants not using this treatment, and their findings have reliably been strongly in favor of those not using standard Western psychiatric treatment, a topic I will turn to now.

**Harms and Benefits of the Treatment Arising from the Medical Model**

Most of the research on schizophrenia has revolved around attempts to understand the etiology of schizophrenia and attempts to specifically define it. The result of over a century of these lines of inquiry have left us, it seems, with little more than a greater appreciation of the mystery of schizophrenia and psychosis and ongoing controversy over theory and semantics. But if our understanding of schizophrenia and the psychotic disorders has advanced remarkably little in all this time, then what can we say about our ability to support those suffering from these conditions? The myth that currently prevails in our society is that schizophrenia is a brain disease and that major ongoing advances have been and continue to be made in regards to the treatment of this disease (Whitaker, 2010). If, however, the research reveals that the first part of this myth (that schizophrenia is a brain disease) actually has very poor validity, then what does this say about the second part of this myth, that the treatment of schizophrenia has been steadily improving?
The results of the research in this regard, it turns out, are in close alignment with the research regarding the brain disease hypothesis—the evidence suggests that the effectiveness of the standard treatment of schizophrenia in the West is actually very poor.

International recovery studies conducted by the World Health Organization have revealed that those diagnosed with schizophrenia in the United States and other "developed" countries fare significantly worse than those in the poorest countries of the world (Hopper et al., 2007). Other reviews suggest that patients diagnosed with schizophrenia in the United States today may fare even worse than asylum patients in the early nineteenth century (Hegarty, Baldessarini, Tohen, & Waternaux, 1994). Why is this happening? Western psychiatry claims to have made many advances in the treatment of the psychotic disorders, so why do we find these extremely poor results? In order to address this question, I will first look more closely at the research which assesses the harms and benefits of the standard Western treatment for schizophrenia (biological psychiatry). I will then look at the research that allows us to do some comparison between the outcomes of biological psychiatric treatment and treatment that has drawn from alternative paradigms.

**Biological psychiatry.** Biological psychiatry, the standard treatment for schizophrenia and the other psychotic disorders in practice today in most so-called developed countries, is based directly on the medical model theory of schizophrenia, and it presently consists primarily of hospitalization of the sufferer and manipulation of the brain, typically via the use of psychotropic drugs (especially antipsychotics, which are often combined with other classes of psychotropic drugs) and occasionally electroconvulsive shock therapy (ECT). Sometimes, patients seek this treatment
voluntarily; at other times, the patients are coerced to “comply” with this treatment in various ways (Hagen, Nixon, & Peters, 2010); and quite often, this treatment is forced on patients without their voluntary consent (Breggin, 2008a). Typically, patients who receive such treatment are told that they have a brain disease (despite the lack of evidence) and that they will most likely have to remain on these very powerful drugs for the remainder of their lives (Hagen et al., 2010), again despite significant evidence to the contrary (Carpenter, McGlashan, & Strauss, 1977; Harding, Zubin, & Strauss, 1987; Harrow & Jobe, 2007; Hopper et al., 2007; Rappaport, 1978). Recovery itself is rarely mentioned by advocates of this model, presumably because it is believed that these patients suffer from a degenerative brain disease in which genuine recovery is essentially impossible. Therefore, the emphasis in this model is generally on symptom management via the use of antipsychotic drugs (Whitaker, 2010). The primary benefits of this treatment that are typically espoused by its advocates are (1) the patients so treated require less hospitalization (Read, 2004) and (2) the symptoms and distress associated with their condition are significantly reduced by such treatment (APA, 2003). I will evaluate these assertions in more detail now.

**The harms and benefits of antipsychotic drugs.** Since the use of antipsychotics (both standard and atypical) is the primary modality used in the standard treatment of schizophrenia in the U.S. and the other developed countries, it is important to look at the research regarding the effectiveness of these drugs, as well as any other harms and benefits.

**Short-term benefit, long-term harm.** Advocates of the medical model often claim that antipsychotics, by reducing symptoms and hospitalizations, have made community
care possible, and they frequently refer to the reduction in the number of occupied psychiatric hospital beds that seem to have corresponded with the introduction of antipsychotics as evidence of this claim (Read, 2004). The research, however, tells a different story. For many of the countries using psychiatric treatment at that time, the number of hospital residents actually increased significantly after the introduction of antipsychotics, and for those countries in which there was a decline, the decline generally began earlier and could be explained by other factors, usually economic (Read, 2004).

Because of the many different factors that affect the number of hospital residents at a given time, attempting to determine the effectiveness of treatment solely by looking at correlations with the number of hospital residents offers little more than mere speculation. Fortunately, there has been a long line of research, extending back nearly 50 years, that addresses this issue more directly, and even though this research is relatively scarce (due primarily to ethical concerns), the findings are surprisingly reliable in showing that while the use of antipsychotics may be of some benefit in the short term, they may actually increase the chronicity of psychosis over the long term (Bola & Mosher, 2003; Carpenter et al., 1977; Chouinard, Jones, & Annable, 1978; Gur, Maany, Mozley, Swanson, & Bilker, 1998; Harding et al., 1987; Harrow & Jobe, 2007; Rappaport, 1978; Schooler, Goldberg, Boothe, & Cole, 1967).

The NIMH studies. In 1964, the NIMH conducted a study that followed 344 patients diagnosed with schizophrenia for six weeks. The participants were divided into two groups—an experimental group that received antipsychotics and a control group that received a placebo (Guttmacher, 1964). After six weeks, the members of the experimental group were faring significantly better, so it first appeared that the
antipsychotics were genuinely helping these participants. However, the one year follow-up assessment revealed that the members of the experimental group had a significantly higher relapse rate: “patients who received placebo treatment in the drug study were less likely [author’s emphasis] to be rehospitalized than those who received any of the three active phenothiazines (thioridazine (Mellaril), fluphenazine (Prolixin), chlorpromazine (Thorazine))” (Schooler et al., 1967, p. 991).

During the 1970s, the NIMH conducted three more similar studies, comparing antipsychotic treatment with different types of environmentally-oriented treatment which minimized the use of psychiatric drugs (Bola & Mosher, 2003; Carpenter et al., 1977; Rappaport, 1978). In all three studies, the members of the groups receiving antipsychotic treatment fared significantly worse. Carpenter et al. (1977) concluded that “antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in the natural course of the illness” (p. 19).

The Agnews Hospital study. In 1978, at the University of California in San Francisco, a 3-year longitudinal study was conducted in which 80 male participants who had recently been diagnosed with schizophrenia were divided into 4 groups—those who had been on chlorpromazine both in the hospital and afterwards (CPZ-on); those who had been on chlorpromazine while in the hospital but were not “medication compliant” afterwards (CPZ-off); those who had been on a placebo while in the hospital and began taking chlorpromazine afterwards (PL-on); and those who began on placebo and remained off antipsychotics the entire time (Rappaport, 1978). All participants remained in the hospital for an average of six weeks, and then were assessed at regular intervals over the following 3 years. They were assessed for severity of illness (SI), where 1 = “no
disturbance” and 7 = “extremely disturbance”; and also for change of clinical status over time (CI), where -1.0 means “worsening on all measures” and +1.0 indicates “improvement on all measures.” See Table 2 for the results obtained after the final follow-up.

Rappaport (1978) found that after the first six weeks, those on the antipsychotics were faring significantly better than those on the placebo, a finding that matched similar findings in other studies. However, within a short time, those off the antipsychotics began to do significantly better, and after 3 years, the group who had never been on antipsychotics (PL-off) fared much better; and the two groups still taking antipsychotics at the end of the study (PL-on and CPZ-on) were faring the worst. The group who had never taken antipsychotics had just one-eighth the percentage of rehospitalizations (only 2 of the 24 participants in this group during the entire 3 years) as the group who remained

Table 2

3-Year Outcome Measures for the Four Different Groups of the Agnews Study

<table>
<thead>
<tr>
<th>Medication Use</th>
<th>n</th>
<th>SI Scale</th>
<th>CI Scale</th>
<th>Rehospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>PL-off</td>
<td>24</td>
<td>1.70</td>
<td>0.92</td>
<td>8% (2)</td>
</tr>
<tr>
<td>CPZ-off</td>
<td>17</td>
<td>2.79</td>
<td>0.52</td>
<td>47% (8)</td>
</tr>
<tr>
<td>PL-on</td>
<td>17</td>
<td>3.54</td>
<td>0.29</td>
<td>53% (9)</td>
</tr>
<tr>
<td>CPZ-on</td>
<td>22</td>
<td>3.51</td>
<td>0.48</td>
<td>73% (16)</td>
</tr>
</tbody>
</table>

Note. SI = severity of illness; CI = change of clinical status over time; PL-off = given placebo in the hospital and never began taking antipsychotics after discharge; CPZ-off= given chlorpromazine in the hospital, but became “medication noncompliant” after discharge to varying degrees; PL-on = given placebo in the hospital but began taking antipsychotics sometime after discharge; CPZ-on = given chlorpromazine in the hospital and remained on it for the duration of the study.
medication compliant for the duration of the study (16 of the 22 participants were rehospitalized in this group). The CPZ-off group participants had begun with antipsychotics in the hospital and were expected to remain on the meds afterwards, but failed to be compliant to differing degrees, which could explain their relatively poor outcome; however, they still demonstrated better outcomes on all measures than either group that remained on the antipsychotics.

Rappaport concluded that those who had never received antipsychotics “showed greater clinical improvement and less pathology at follow-up, fewer rehospitalizations and less overall functional disturbance in the community than the other groups of patients” (p. 106). This is one of the few studies ever conducted that was able to use randomized neuroleptic-naïve (never exposed to antipsychotics) participants, since such methodology has generally been considered unethical (Carpenter et al., 1977; Rappaport, 1978; an ironic concern given that the findings in this study suggest it might be unethical not to consider avoiding the use of antipsychotics for many of these individuals.)

*The Vermont study.* The Vermont Longitudinal Research Project (Harding et al., 1987) was a schizophrenia recovery study that still inspires tremendous hope. In it, the Vermont State Hospital discharged 269 of the most chronically psychotic from their back wards. These patients were placed in the community with support in place and then followed for an average of 32 years. The participants of this cohort had been suffering from schizophrenia for an average of 16 years, had been completely disabled for an average of 10 years and considered to be some of the most hopeless cases in the hospital. Upon the final follow up (an average of 32 years later), nearly one half (45%) of those still alive were completely asymptomatic and considered to be fully recovered. In a recent
interview with the American Psychological Association Monitor, Harding said that all participants who had recovered in this study had one thing in common: they all “had long since stopped taking medications” (as quoted in Whitaker, 2010, p. 109).

The Chicago study. The most recently conducted schizophrenia recovery study, which was funded by the NIMH, was a 15-year longitudinal study that directly compared the outcomes of one group of participants who were using antipsychotics with a second group of participants who were not using antipsychotics (Harrow & Jobe, 2007), and the results revealed dramatic differences in their outcomes: The group not taking antipsychotics fared significantly better. They had nearly eight times the recovery rate and only one-third the number of those considered to have a “uniformly poor” outcome.

Table 3

15-Year Outcome Measures for the Two Groups in Harrow’s Study

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>On Antipsychotics (n=39)</th>
<th>Off Antipsychotics (n=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uniformly Poor</td>
<td>49%</td>
<td>16%</td>
</tr>
<tr>
<td>Fair Outcome</td>
<td>46%</td>
<td>40%</td>
</tr>
<tr>
<td>Recovered</td>
<td>5%</td>
<td>44%</td>
</tr>
</tbody>
</table>

Why the increased chronicity of psychosis from antipsychotics? Chouinard et al. (1978) were among the first to suggest that the reason these studies were showing a higher rate of relapse for those taking antipsychotics is that the antipsychotics affect the brain in ways that make the individual more vulnerable to psychosis. Chouinard et al. posited that the brain attempts to compensate for the effect of these drugs by increasing
the number of dopamine receptors, which subsequently increases the individual’s susceptibility to psychosis (a condition often referred to as *tardive psychosis*—psychosis caused by the drugs), a hypothesis that still holds weight today (Whitaker, 2010). A closely related hypothesis has been generated and validated with the invention of the MRI. It was discovered that antipsychotic drug use (both of the older *typicals* and the newer *atypicals*) causes atrophy of the cerebral cortex and enlargement of the basal ganglia (Chakos et al., 1994; Gur et al., 1998; Madsen, Keiding, Karle, Esbjerg, & Hemmingsen, 1998), changes which have been demonstrated to increase the severity of both positive and negative psychotic symptoms (Gur et al., 1998). So while antipsychotics may be useful to some individuals in reducing their symptoms during the onset of acute psychosis, the evidence has been surprisingly robust in demonstrating that the long-term use of antipsychotics increases the likelihood of chronic psychosis.

**Other physical, emotional, and cognitive problems.** Antipsychotic drug use has not only been shown to increase the likelihood of chronic psychosis, but it has also been shown to frequently cause a host of other physical, emotional, and cognitive problems which have the potential to be severely debilitating and may even lead to a significantly shortened life span.

*Tardive dyskinesia.* Tardive dyskinesia is a disorder of the voluntary nervous system that results from permanent damage to the basal ganglia, a region of the brain important in motor control (APA, 1992). The resulting symptoms are uncontrollable movements of the tongue and other parts of the body, which result in difficulties with speaking, eating, walking, and even sitting still. It is estimated that about 5% of patients
taking antipsychotics develop this disorder within the first year, with an additional 5% of patients developing it with every subsequent year (Breggin, 2008a).

Akathisia. Whitaker (2007) described akathisia as “an inner restlessness and anxiety that many patients describe as the worst sort of torment” (p. 8). Research has shown high correlations between akathisia and suicidality, homicidality, and other violent behavior (Breggin, 2008b; Galynker & Nazarian, 1997; Shear, Frances, & Weiden, 1983; Wirshing, Van Putten, Rosenberg, & Marder, 1992).

Cognitive impairment. Research has found that antipsychotics typically cause some level of cognitive impairment, especially regarding the capacity to learn, retain information, and to perform executive functions, such as problem solving and planning (Hagen et al., 2010; Keefe, Bollini, & Silva, 1999).

Emotional impairment. It has long been recognized that antipsychotics cause emotional deadening, which on one hand is most likely the primary effect that reduces distressing emotions associated with psychosis, but on the other hand often results in a lack of joy and meaning in life (Breggin, 2008a). In a recent qualitative study in which 28 participants who were self-identified as recovered were interviewed, the authors concluded that “by far the most common and disturbing side effect was a chronic sense of ‘numbness’ and/or lack of emotion, associated particularly with the use of antipsychotics” (Hagen et al., 2010, p. 50). These participants described the antipsychotics as resulting in “not feeling anything,” “feeling isolated,” “being completely numb,” and feeling like “a complete, drooling zombie” (p. 50).

Suicidality. Recent research suggests schizophrenia patients who are given antipsychotic treatment today commit suicide at a rate twenty times higher than that of
schizophrenia patients prior to the introduction of antipsychotic treatment (Healy et al., 2006). This is an astonishing figure, and it is important to keep in mind that this represents a correlation, and not necessarily causation; nonetheless, given the magnitude of this correlation, it would be difficult to deny the role that antipsychotics are likely play in this increased suicide rate.

Other physical health problems. A host of other serious physical problems has been associated with antipsychotic treatment, including blindness, seizures, arrhythmia, fatal blood clots, heat stroke, swollen breasts, leaking breasts, sexual dysfunction, skin rashes, obesity, diabetes, agranulocytosis (potentially fatal loss of white blood cells), and a significantly shortened life span (Arana, 2000; Joukamaa et al., 2006; Waddington, Youssef, & Kinsella, 1998).

Newer atypical antipsychotics. It was hoped that atypical antipsychotics, which are somewhat different than typical antipsychotics in that they target a slightly different pattern of neuroreceptors, would offer improved symptom management with fewer side effects than the typicals. However, as the research has been accumulating, it appears that this hope has not been realized. While the side effect profile is somewhat different, it seems that the overall risk is relatively similar, and some argue that the overall risk of the atypicals may even be worse (Davies et al., 2007; Knable, Heinz, Raedler, & Weinberger, 1997; Mattes, 1997; Rosebush & Mazurek, 1999).

In 1994, risperidone (Risperdal) was the first atypical antipsychotic to be released in the U.S. as a first-line agent in the treatment of schizophrenia, and it is still one of the most widely used atypicals today (Cullen, Kumra, Regan, Westerman, & Schulz, 2008).
Upon approval, the Food and Drug Administration (FDA) concluded that risperidone was neither more effective nor safer than any of the typical antipsychotics:

We would consider any advertisement or promotion labeling for RISPERDAL false, misleading, or lacking fair balance under section 501(a) or 501(n) of the Act if there is presentation of data that conveys the impression that risperidone is superior to haloperidol or any other marketed antipsychotic drug product with regard to safety or effectiveness. (Department of Health and Human Services, 1993, p. 4)

Later, researchers concluded that risperidone had a higher incidence of Parkinsonian symptoms and akathisia than haloperidol (a popular typical antipsychotic; Knable et al., 1997; Rosebush & Mazurek, 1999); and Mattes (1997), director of the Psychopharmacology Research Association, concluded that risperidone may actually be less effective than the typical antipsychotics for managing positive psychotic symptoms.

As other atypical antipsychotics entered the market, the research demonstrated that they performed similarly poorly. In 2000, a group of researchers at Oxford University conducted a meta-analysis of 52 studies, with a total of 12,649 patients and a variety of atypical antipsychotics, and the authors concluded: “There is no clear evidence that atypicals are more effective or are better tolerated than conventional antipsychotics” (Geddes, Freemantle, Harrison, & Bebbington, 2000, p. 1371). In 2005, the NIMH concluded that the atypical antipsychotics performed no better than the typicals regarding their efficacy or the likelihood that patients would tolerate them (Lieberman et al., 2005); and in 2007, a British government study concluded that patients using atypical antipsychotics had a worse quality of life than those who were using the older typical antipsychotics, and this in spite of the fact that this same group of researchers considered patients on the older antipsychotics to have a very poor quality of life (Davies et al., 2007).
Finally, the research suggests that the atypical antipsychotics may cause more adverse physical ailments than the typicals. While they do seem to have less impact on the dopaminergic pathways of the brain than the typicals, they affect other pathways (especially those which use serotonin and glutamate) in ways that the typicals do not, and this may lead to more serious physical problems (especially agranulocytosis, metabolic dysfunction, and diabetes) with a correspondingly higher likelihood of early death (Whitaker, 2007).

**Medical model treatment resulting in an increase of stigma and hopelessness.**

Besides the heavy use of drugs with severe side effects, there are other unfortunate consequences of trying to apply the medical model to the treatment of those suffering from extreme states of consciousness. Perhaps one of the largest is the attitude of dehumanization, stigma (both from others and internalized), and hopelessness (both from others and internalized) when one is labeled with a “mental illness” (Mehta & Farina, 1997). Research has shown that when people are so labeled, others are likely to see their behavior and experiences as meaningless acts of a disease, which increases the tendency for these individuals to be stigmatized and feared (Geekie & Read, 2009). Markowitz (2005) researched how this labeling can lead to a self-fulfilling prophecy. Certain negative stereotypes typically come with the label of mental illness, and when one is so labeled, he or she is at risk of personally identifying with these stereotypes as well as trying to minimize being so stereotyped by others. This often results in a self-fulfilling prophecy, in which the individual begins to experience a reduction in self-esteem and confidence and then is likely to withdraw socially in order to avoid being rejected by others. This results in a reduction of friends and employment, which leads to further
stress and reduced self-esteem, and an ever increasing downward spiral towards increased emotional and psychological distress (Markowitz, 2005).

**Medical model treatment resulting in trauma.** Another factor that almost certainly hinders recovery in the West is that people diagnosed with schizophrenia and other psychotic disorders are often treated in a manner that is frightening, disempowering, and often even violent. The following scenario may help to illustrate this point:

Imagine for a moment that you are struggling with a highly distressing extreme state of mind (i.e., psychosis). Upon seeking help (or perhaps receiving it unintentionally), it is possible that you may be physically restrained without first being given the opportunity to be really listened to, forced to take toxic and debilitating drugs, and have your freedoms and many of your rights taken away from you indefinitely (Breggin, 2008a). This treatment clearly has the potential to result in feelings of horror, disempowerment and helplessness (what many describe as the benchmark of trauma; APA, 2000b; Herman, 1997; Levine, 1997); yet, in addition to this treatment, it is likely that you will be told you have a brain disease that will probably last for your entire lifetime with little hope of genuine recovery (Hagen et al., 2010), further exacerbating any feelings of helplessness and hopelessness you are probably already experiencing. This kind of treatment may lead to the direct development of posttraumatic stress symptoms (Herman, 1997; Levine, 1997), which may compound the distress you are already experiencing. Now that you have been so labeled, because of the mental illness paradigm prevailing in Western society, it is likely that you will find yourself being stigmatized and seen by others as “crazy,” and it is likely that you will internalize this
stigma, seeing yourself as hopelessly damaged (Geekie & Read, 2009; Markowitz, 2005; Mehta & Farina, 1997).

These factors are likely to collude with and reinforce the distress associated with psychosis, creating a downward spiral. In other words, when one is struggling with extreme states of mind, it is likely that the medical model paradigm within Western society actually exacerbates the distress, leading to an ever worsening spiral into distressing emotions, overwhelming experiences, and intrapsychic conflict (Modrow, 2003). In a final tragic twist to this painful dilemma, it then seems that one of the few ways our society offers to deal with this tragic dilemma is to create genuine brain disease (through brain-damaging drugs, electroshock therapy, and/or other similarly harmful means) in an attempt to numb these individuals to their unbearable suffering.

_Are we generating a self-fulfilling prophecy of “no recovery”?_ After reviewing the research and the relevant literature pertaining to the medical model theory of schizophrenia and recovery from schizophrenia, it is evident that the medical model has very poor validity and that recovery is very common, even being the norm in many regions of the world. Yet, in spite of this, there is still the widespread belief in Western society that (a) schizophrenia has been conclusively determined to be a brain disease, and (b) genuine recovery is very unlikely and perhaps not even possible. So, why is there such a dramatic disparity between these widespread beliefs and the results of the research?

A thorough response to this question falls outside the scope of this review; however, the research I have presented so far does offer some interesting implications. First, the evidence suggests that the primary modality that we use in the West for treating
schizophrenia (involving primarily the use of antipsychotics and the insistence that one accepts that one has a “mental illness”) significantly increases the likelihood that individuals experiencing one psychotic episode will go on to develop a chronic psychotic condition; and closely related to this, the research suggests that this treatment greatly reduces the likelihood of recovery, and especially full recovery. This treatment is prevalent in Western society, with the large majority of those diagnosed with schizophrenia and other psychotic disorders in Western industrialized countries receiving it. Is it possible that our beliefs are actually generating a self-fulfilling prophecy? By assuming brain disease and the hopelessness of real recovery, is it possible that we are unwittingly treating these individuals in such a way that prevents real recovery and therefore perpetuates these myths?

Comparing the Outcomes Between Medical Model Treatment and Alternative Treatment Modalities

The evidence presented so far has shown that the treatment for schizophrenia arising from the medical model paradigm may have some limited benefits--specifically, if medications are offered in a way that does not cause further trauma or disempowerment, they have been shown to be effective for many individuals in reducing the distress caused by positive psychotic symptoms in the short term. However, the evidence has also shown that the treatment guided by the medical model very often has severe side effects—an increased likelihood of relapse for psychosis and chronic psychosis (tardive psychosis); health problems such as diabetes, metabolic disorders, tardive dyskinesia, agranulocytosis, and obesity; a reduced lifespan; higher rates of violence and suicide; and increased stigmatization, hopelessness, and trauma. I will now turn to explore this issue more holistically, looking at the research that has directly measured outcomes of various
treatment modalities with the intention of making a direct comparison between the outcomes for those who have been treated within the medical model paradigm and those treated with alternative treatment models. Before addressing this research, however, it will help to first present the following scenario to illustrate the core principles that typically accompany the most successful alternative treatment modalities.

Again, imagine that you are struggling with a highly distressing extreme state of mind (i.e., psychosis). This time, however, you live in a society or a community that validates your experience. Your beliefs may be challenged, but not your underlying experience. You will not be locked up against your will or forced to ingest debilitating drugs. You will not be told that you have a diseased brain with no hope of real recovery, but rather, there is the strong assumption that you will recover, and even that your experiences may eventually allow you to contribute to your community in a particularly unique and powerful way. Your needs for choice, dignity and respect will be held—your mind, body, and spirit will not be invaded. You find that people listen to your suffering with empathy and compassion rather than fear and judgment.

It stands to reason that, given such an environment, distressing emotions that typically accompany psychosis (terror, rage, despair, and confusion) will have a difficult time becoming firmly established, and your distress will most likely not be further exacerbated (Modrow, 2003). As Westerners, we may have a difficult time believing that such a response to someone suffering with such extreme mind states could be possible, but this is actually much closer to the paradigm found in collectivistic societies (Clarke, 2001; House, 2001; Perry, 1999), and it has been found that people diagnosed with
schizophrenia and other psychotic disorders in such societies have a much higher rate of recovery than those diagnosed with similar disorders in the West (Hopper et al., 2007).

**The World Health Organization (WHO) studies.** The WHO studies, including the 15-year and 25-year longitudinal studies listed above in Table 1, as well as the 2-year and 5-year studies which preceded them, have demonstrated a very interesting point with very high reliability (remaining highly significant across all four of their studies): Those suffering from schizophrenia in so-called developed countries have far worse outcomes than those who live in so-called developing countries (Hopper et al., 2007). When the 13 countries that participated in these studies were divided into two categories of developed (such as the U.S. and Russia) and developing countries (such as India, Nigeria, and Columbia), the residents of the developing countries fared significantly better, regardless of which criteria was used to determine outcomes. For example, when looking at the participants who were assigned a Global Assessment Functioning (GAF) of greater than 60 at the end of the study, 43% of those in the developed countries satisfied this criteria, as compared to 70% of those in developing countries (Hopper et al., 2007). The use of antipsychotic medication (and presumably the medical model paradigm of treatment) is inversely correlated with these figures: 61% of those in the developed countries were regularly maintained on antipsychotics, as compared to only 16% of those in the developing countries. The participants of Agra, India, had the best overall outcomes, and only 3% of them were maintained on antipsychotics. Of course, there are likely many factors that play a role in this strong disparity in outcomes, but the treatment modality must certainly play a particularly significant role (Read, 2004; Whitaker, 2007, 2010).
**Alternative residential communities in the West.** Even in the West, there have been residential facilities designed to provide a similar kind of care for those recovering from extreme states of mind as that which is often naturally provided within many collectivistic societies. Residents of such homes, who are diagnosed with severe mental disorders, are given freedom and empathy, are not forced to take psychiatric drugs (although are allowed access to them if they so desire), are not forced to remain in the home against their will, and are encouraged to be an active member of the community, both within the residence and in the community at large. There have not been many such homes, however, and so the research on them is somewhat limited. However, the research that does exist is quite promising.

Mosher, once Chief of the Center for Studies of Schizophrenia at the NIMH, opened such a facility in 1969 in San Francisco, naming it the *Soteria house*, with the intention of performing a well-controlled research study originally funded by the NIMH (Bola & Mosher, 2003; Mosher, 1999; Mosher & Hendrix, 2004) In a two-year longitudinal study, patients who were hospitalized with their first psychotic episode and who volunteered to participate were randomized into two groups—with members of one group moving into the Soteria house and members of the other group receiving standard psychiatric treatment. After two years, the Soteria residents showed equal or better outcome measurements on all eight assessment points, having demonstrated the largest gains in the areas of psychopathology, social functioning, and employment. Also, a significantly higher percentage of the Soteria house residents were living independently, had fewer hospital readmissions, and far fewer of them were using psychiatric drugs (Bola & Mosher, 2003).
Unfortunately, the Soteria house was closed down in 1983 due to a lack of funding. Since then, due to the laws allowing forced antipsychotic drug treatment, which have come to be the norm in most states, there has been a legal barrier to starting another similar home. Fortunately, in 2006, Gottstein, a lawyer in Alaska who founded the nonprofit organization, PsychRights, managed to persuade the Alaska State Supreme Court to overturn the forced antipsychotic drug treatment law; and in 2009, a Soteria house finally opened its doors for the first time in the US in 26 years (in Anchorage, Alaska; Whitaker, 2010).

Other similar residential homes have been, and continue to be, operated in Western society with similar results (Perry, 1999; Seikkula et al., 2006; Whitaker, 2007), though there have not been any in the US until 2009. After reviewing the results of the studies that looked at the efficacy of such homes, Mosher (1999) concluded that “85% to 90% of acute and long-term clients deemed in need of acute hospitalization can be returned to the community without use of conventional hospital treatment” (p. 142). His conclusion was further corroborated by a more recent study, in which participants of a similar program in Finland were followed for five years after being initially diagnosed: 86% had returned to work and/or school, and 82% of them were considered to be fully recovered. They “did not have any residual psychotic symptoms” and were not using any psychiatric drugs (Seikkula et al., 2006, p. 214).

A Summary of the Research on Schizophrenia and Recovery

As we have seen, piecing together the evidence regarding recovery from long-term psychosis is no simple and straightforward task. However, we have also seen that
there are certain findings that have demonstrated high consistency and reliability across this disparate array of research; and I will summarize these here:

(1) In spite of over a hundred years of research and billions of dollars spent, we still have not found any clear evidence of a biologically-based etiology of schizophrenia, nor have we been able to validate that schizophrenia itself is even a valid construct (there is no doubt, however, that many people suffer from distressing anomalous experiences, what I have been referring to as psychosis, and that these are the individuals who often get labeled as having schizophrenia).

(2) The use of antipsychotics helps reduce the positive symptoms of psychosis and the associated distressing emotions for many people in the short term (during the first six weeks or so).

(3) The long-term use of antipsychotics increases the likelihood of the development of a chronic psychotic condition and significantly reduces the likelihood of recovery (as well as carrying the high likelihood of causing other serious physical, cognitive, and emotional impairments). The specific effects of such use clearly vary significantly from one individual to another, but generally speaking, this has been a surprisingly consistent and reliable finding.

(4) Those individuals who are never exposed to antipsychotics have the highest chance of recovery.

(5) Regardless of the treatment method, it seems that there is always some percentage (although relatively small) that is likely to remain in a chronic psychotic condition indefinitely.
(6) The medical model paradigm, with its associated beliefs of brain disease and terminology such as “mental illness,” can significantly increase stigma, fear, hopelessness, and other associated distressing emotions and behavior.

(7) Residents of so-called developing countries have much higher recovery rates than those in so-called developed countries, and the use of antipsychotics and the medical model paradigm of treatment is inversely correlated with recovery in these studies.

(8) Residential facilities that offer continuous empathic support and freedom, and which minimize the use of antipsychotics, have demonstrated the ability to provide significantly better outcomes for their residents at significantly less cost than what the standard psychiatric model of care has been able to provide. However, they may reduce secondary gains (e.g., personal income, job security, sense of order and control in their environment, etc.) for many professional caregivers (i.e., psychiatrists, psychiatric nurses, etc.) and those in the psychiatric drug industry.

When looking at the summary of the research, it is difficult to deny that the medical model theory of psychosis has been a colossal failure, both in establishing significant validity and in offering guidance for supporting those suffering from psychosis. Fortunately, there is another theoretical model that arguably fits the evidence much more accurately.

**Seeing Psychosis as a Natural Coping/Healing/Growth-Oriented Process**

The recovery research strongly suggests that, when supported in a compassionate and empathic environment, psychosis often (and perhaps even ordinarily) resolves automatically. In addition to this, there is significant evidence that a psychotic episode sometimes “appears to function as a breakthrough to a higher level of mental and
emotional functioning” (Siebert, 1999, p. 183). Arieti (1978), a lifelong clinician specializing with clients who have received a diagnosis of schizophrenia, said, “With many patients who receive intensive and prolonged psychotherapy, we reach levels of integration and self-fulfillment that are far superior to those prevailing before the patient was psychotic” (p. 20). Perry (1999), another lifelong clinician who served as the clinical director of Diabasis, a medication-free residential facility for young adults who were considered severely psychotic, said that “85 percent of the clients in Diabasis not only improved, with no medication, but most went on growing after leaving us” (p. 147). In a recent study conducted by Tooth et al. (2003) involving 57 participants who had been diagnosed with schizophrenia and who now identify as being “in recovery,” 66% of them describe their functioning as better (and 44% of these as much better) than that prior to the development of schizophrenia. In this same study, 62% describe their social situation as better (with 31% of these as much better) then that prior to their development of schizophrenia.

A number of scholars and clinicians have suggested that the reason we see these kinds of results is that psychosis may actually be the manifestation of a natural attempt of a psyche to survive and/or heal from an untenable situation or way of being; and therefore, successful resolution of a psychotic episode would naturally entail healing from and/or growth beyond the former set of circumstances (Arieti, 1978; Clarke, 2001; House, 2001; Karon & VandenBos, 1996; Laing, 1967; May, 1977; Mindell, 2008; Mosher & Hendrix, 2004; Perry, 1999). Laing (1967) closely studied the social circumstances surrounding over 100 cases in which and individual was diagnosed with schizophrenia, and he found that “without exception the experience and behavior that gets
labeled schizophrenic is *a special strategy that a person invents in order to live in an unlivable situation* [author’s emphasis]” (pp. 114-115). Karon, a clinician specializing in psychotherapy for those diagnosed with psychotic disorders stated his belief (in an interview in Mackler, 2008) that any one of us would also likely experience psychosis if we were to have to live through the same set of circumstances as those of his psychotic clients.

These people, then, who are so often labeled as “crazy” may actually be doing the best they can to simply survive what they perceive to be extraordinary circumstances, and when one is confronted with extraordinary circumstances, one often must resort to extraordinary strategies, strategies which may appear completely absurd to those of us who do not understand the full scope of what it is with which the individual is struggling. When viewing these individuals through this lens, then, we can say that there is nothing at all inherently wrong with those who suffer from psychosis. They are merely acting as any living organism would in the same situation—they are simply trying to survive, and ultimately aspiring to thrive. *Transpersonal psychology* is one field of Western psychology that has invested significant time and resources into grappling with this idea. One offshoot of this idea that has become particularly prevalent in the field of transpersonal psychology is the idea that perhaps there are two distinct categories of psychotic experiences—mystical experiences and so-called genuine pathological psychosis, a topic I will turn to now.
In most cultures throughout human history, it has been widely believed that those who experience anomalous experiences or madness may be contacting and/or interacting with spiritual realms of which the majority of the population is unaware, experiences commonly referred to as mystical experiences. However, as the understanding of psychosis has come to be increasingly dominated by the medical model in the West, this belief has become increasingly challenged. This has led to significant debate and controversy regarding how and even if we should make the distinction between so-called mystical experiences and so-called genuine pathological psychosis. In the field of psychiatry and even mainstream psychology, the general stance regarding this discussion is quite simple—all such experiences, whether their content appears to be of a mystical nature or not, represent psychopathology (Grof, 2000). It is likely that most members of psychiatry as well as many members of mainstream psychology would take this conclusion one step further, adhering to a strict belief in the medical model and therefore claiming that the root cause underlying all anomalous experiences is a dysfunctional brain (APA, 2003). Transpersonal psychology, however, is a branch of Western psychology that has taken a very different stance.

Transpersonal psychology is one of the few branches of Western psychology that has looked closely at this issue; in fact, it can be said that discussion of this issue is one of the key defining aspects of transpersonal psychology. Sutich, one of the founders of transpersonal psychology described the new transpersonal movement as emphasizing unitive consciousness, mystical awakening, and peak experiences (Taylor, 1999). Other
definitions have since been given, but most of them agree that the themes most relevant to transpersonal psychology are spiritual experience and practice, states of consciousness, higher and highest potential, experiences beyond the personal self, and transcendence (Lajoie & Shapiro, 1992). Since the birth of the transpersonal movement in the early 1960s, numerous models that attempt to explain mystical experiences have emerged within it, though there has been extensive overlap among them. One area in which the overlap is particularly significant is in the descriptions of spiritual emergence and spiritual emergency.

**Spiritual Emergence vs. Spiritual Emergency**

In transpersonal psychology, mystical experiences are generally divided into two categories, depending upon their level of intensity. Spiritual emergence is the condition in which altered states of consciousness and other marginally psychotic phenomena may be experienced, but the individual is able to cope with them in a way that does not significantly interfere with other aspects of their life. Of course, the degrees and intensity of this process will inevitably vary from time to time, but someone experiencing spiritual emergence would not say they felt overwhelmed by the experience. Spiritual emergency, on the other hand, refers to a sudden and potentially overwhelming plunge into such experiences. Curttright (1997) defined spiritual emergency more specifically as a process in which “the self becomes disorganized and overwhelmed by an infusion of spiritual energies or new realms of experience which it is not yet able to integrate” (p. 156).

It is generally agreed that there are two variables that, when occurring together, tend to open the doorway to a spiritual emergency. The first is any mystical experience that is particularly difficult to integrate, and the second is the experience of some sort of
stress. Regarding the first variable, presumably those experiences that are the most
difficult to integrate are the ones that most directly challenge an individual’s personal
understanding of the world and of themselves. Regarding the second variable, when a
person is particularly stressed, his or her defenses and inner resources are likely to be
weakened. According to Cortright (1997), “it may be this very vulnerability or ‘thinning’
of the person’s ego structures that allow spiritual experiences past the usual filtering
mechanisms of the psyche” (p. 160). He said these stressors may be either physical,
emotional, or spiritual, or some combination thereof. Physical stressors frequently
include near-death experiences, pregnancy and childbirth, fasting, injury, or physical
hardship. Emotional stressors frequently include emotional deprivation or loss,
experiences that evoke emotional intensity, drugs (especially psychedelic drugs), and
intense sexual experiences. Spiritual stressors typically involve some kind of intensive
spiritual practice, such as intensive meditation retreats or vision quests.

**Spiritual Emergency vs. “Genuine” Psychosis**

According to Turner, Lukoff, Barnhouse, and Lu (1995), these stressors have
been known to not only trigger spiritual emergency but also what they believe is more
“genuine” psychosis, a point that brings us to another major and controversial topic of
discussion within the field of transpersonal psychology: How do we distinguish spiritual
emergency from genuine psychosis, and is such a distinction even valid? If we were to
interpret the concepts of spiritual emergence and spiritual emergency using the
definitions I posited earlier, a spiritual emergence would consist primarily of non-
distressing anomalous experiences, whereas a spiritual emergency would most likely
involve a significant number of distressing anomalous experiences. This then brings us to
a very important question: Are there really two distinct and unrelated processes involving anomalous experiences—spiritual emergency and psychosis? Or are both of these merely different manifestations of one common underlying process?

A common assumption held by many, but not all, transpersonally-oriented psychologists is that while the line between spiritual emergency and psychosis is often faint, such a line does exist. These psychologists typically argue that spiritual emergency is a mystical experience that has the potential for great healing and beneficial transformation when the process is allowed to complete, whereas psychosis is purely regressive and needs to be checked as quickly as possible to avoid an ever worsening spiral into degeneration (Turner et al., 1995; Wilber, 2000). The implications of this argument are that the most helpful interventions for each category of experience are essentially opposite, leading to a situation in which it is very important to distinguish one from the other.

A number of different models that attempt to aid in making such distinctions have been posited by various transpersonal practitioners, including Assagioli (1989), Grof and Grof (1989), Nelson (1990), Wilber (2000), and others. There has been substantial overlap between them, however, especially regarding the belief that an important distinguishing factor is the ability of an individual going through such experiences to maintain insight into the process and the ability to distinguish between the individual’s own process and consensus reality. Cortright (1997) wrote, “There is a better chance that some observing ego is present in spiritual emergency than in a mental disorder. Many times in spiritual emergency the person is afraid of going crazy whereas in psychosis the person is crazy and lost in the experience, that is, there is little or no observing ego” (p.
Table 4

*Suggested Similarities and Distinctions between Mystical and Psychotic Experiences*

<table>
<thead>
<tr>
<th>Similarities</th>
<th>Distinctions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Content</strong></td>
<td></td>
</tr>
<tr>
<td>Religious or paranormal content</td>
<td>Sub-culturally based, socially accepted/idiosyncratic, bizarre, alienating</td>
</tr>
<tr>
<td>Belief in personal mission, divine calling</td>
<td>Humility, recognition of personal fallibility/grandiosity, sense of infallibility</td>
</tr>
<tr>
<td>Experience of discarnate entities, “sense of presence”</td>
<td>Benign, recognized entity/malignant, idiosyncratic entity</td>
</tr>
<tr>
<td>Sense of being guided by external power</td>
<td>Volitional control is retained/involitional</td>
</tr>
<tr>
<td>Intense emotional experience</td>
<td>Positive emotions/negative emotions</td>
</tr>
<tr>
<td><strong>Form</strong></td>
<td></td>
</tr>
<tr>
<td>Hallucinations—visions and voices</td>
<td>Pseudo/true hallucinations</td>
</tr>
<tr>
<td></td>
<td>Visual/auditory modality</td>
</tr>
<tr>
<td></td>
<td>Mood congruent, coherent, friendly/“first rank”, chaotic, critical hallucinations</td>
</tr>
<tr>
<td>Delusions/revelations</td>
<td>Corrigible/incorrigible beliefs</td>
</tr>
<tr>
<td></td>
<td>Comprehensible/bizarre beliefs</td>
</tr>
<tr>
<td></td>
<td>Presence/absence of “insight”</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td>Transient vs. extended in time</td>
</tr>
<tr>
<td>Creative problem-solving process (impasse—insight—resolution)</td>
<td>Spiritual fruits (humility, altruism, creativity)/mental illness (self-centeredness, inability to function)</td>
</tr>
</tbody>
</table>
Jackson (2001) has put together a table (Table 4) that highlights most of the similarities and distinctions between mystical and psychotic experiences that have been suggested to date, mostly from the field of transpersonal psychology.

**The Evidence Suggests that Mystical and Psychotic Experiences Both Arise From a Common Process**

The desire to make the distinction between mystical and psychotic experiences is certainly understandable if it is believed that the most helpful interventions are vastly different for each category. What is particularly ironic, however, is that while, by definition, transpersonal psychologists believe that the root foundation of our experience is not material (Cortright, 1997), a number of the major transpersonally-oriented contributors to this topic continue to validate the psychiatric medical model category of mental illness when attempting to make these distinctions. Lukoff (1985), for example, discussed how difficult it is to distinguish between psychotic and mystical experiences, saying that “the task requires familiarity with the psychiatric perspective” (p. 161), where *the psychiatric perspective* presumably refers to the psychiatric medical model, which is based on the premise that consciousness and all mental phenomena are merely epiphenomena of neurological activity arising within the material brain.

The question raised here is, why are some transpersonally-oriented researchers attempting to place one category of experience into the medical model paradigm, which is founded on the assumption that our essential nature is material, and the other category of experience into the transpersonal model, which is founded on the assumption that our essential nature is spiritual (i.e., that consciousness and associated mental phenomena originate in a realm beyond/beneath matter, even though they may manifest through and interact with matter, such as the brain; Grof, 1986).
It could be argued that these psychologists are attempting to hold paradox—seeing the validity in both the reductionistic medical model and the transpersonal perspective—an argument that might at first glance appear to hold some merit. However, I do not believe that the difference between the medical model and the transpersonal model is about perspectives, but it is a core epistemological difference regarding the fundamental essence of human nature. One side posits that the root-most foundation of our experience is material, and the other side posits that it extends beyond the material realm. I believe these epistemologies are mutually exclusive, with each of them leading to radically different implications for how best to support those suffering from such experiences. One significant result of this confusion, I believe, is the transpersonal movement stifling its own progress by attempting to accommodate the medical model and the biological psychiatric “treatment” arising from that model. This is a point that brings up another question: Is it true that these transpersonally-oriented researchers and clinicians are simply trying to accommodate the medical model, or are they having trouble truly shedding the biases and assumptions that are so deeply embedded in the societies in which they live? House (2001) noted that “it is all too easy for ‘new paradigm’ thinkers to delude themselves that they have transcended the modernist paradigm” (p. 123), and he points out just how difficult it is for any of us to shift our thought habits off the beaten path of the culture in which we were raised.

Regardless of how stubborn our thought habits may be, however, the emerging evidence, both clinical and otherwise, appears to be demanding a fundamental shift. As discussed earlier, there is still no substantial evidence that psychosis (whether considered mystical or otherwise) is the result of a dysfunctional brain (Bentall, 2003, 2004;
Breeding, 2008; Breggin, J., 2008; Read, 2004; Seibert, 1999; Szasz, 2008; Whitaker, 2010). In addition to this, there has been a significant number of studies with participants who have experienced such anomalous experiences, and in virtually every case, their experiences are not neatly divided along the clear division indicated in Table 4 (Chadwick, 2001; Clarke, 2001; Jackson, 2001; Jackson & Fulford, 2002; Margree, 2002; Peters, 2001). Rather, most of these participants experienced some degree of both categories of experience—both mystical and psychotic. Some expressed alternating between one category and the other; some expressed having experiences that fit mostly into one category while still occasionally or subtly having experiences in the other category; and others seemed to experience no clear division at all, having experiences from both sides relatively equally and even simultaneously.

So, if we take this emerging research seriously and acknowledge that the similarities in both categories of experience apparently far outweigh the differences, then where does this leave us? An advocate of the medical model would quickly suggest that this evidence must indicate that all of these experiences are the result of a dysfunctional brain. There are several major problems with this conclusion, however. First, as described above, there is a striking lack of evidence of brain pathology associated with such experiences and second, as discussed earlier, it is well established that a significant number of people fully recover from psychosis and so-called schizophrenia (Bentall, 2004; Breeding, 2008; Calabrese & Corrigan, 2005; Hopper et al., 2007; Siebert, 1999; Whitaker, 2002, 2010).

If we want to remain somewhat faithful to the model and terminology presented by the field of transpersonal psychology while also accommodating the emerging
research, rather than continuing to make attempts to draw clear distinctions between spiritual emergency and genuine psychosis in the face of such contrary evidence, perhaps it would be more accurate to consider that all of these experiences arise from a common underlying coping/healing/growth-oriented process, but that the substantial variation we see in the manifestation of this process and perhaps even the outcomes in recovery can be seen as a result of the strength of the observing ego that is present. By applying such a model, we may discover that those experiences that lie closer to the strong observing ego end of the continuum would be more appropriately termed spiritual emergency, whereas those experiences that fall closer to the no observing ego end of the continuum would be more appropriately termed psychosis.
As demonstrated in the literature review so far, a surprisingly wide array of lines of inquiry have all been converging on the prospect that psychosis may be a manifestation of a natural coping/healing/growth-oriented process initiated by the psyche (which I will hereafter refer to as a growth-oriented process). A number of scholars, clinicians, and researchers have generated theoretical models based upon this premise, and I will devote the final section of this literature review to present those models I have come across that I believe are most compatible with this research. It is important to note that while some of these models may appear to differ dramatically from some of the others, since they each emphasize different aspects and perspectives of the psychotic process, they do not necessarily exclude each other.

**Psychosis as a Renewal Process**

Perry (1999) was a Jungian-oriented psychiatrist with more than forty years’ experience working clinically with individuals suffering acute psychotic episodes (who were typically diagnosed with so-called schizophrenia). He had the rare opportunity to perform many years of deep psychotherapeutic work with people going through these episodes without the use of medication. He concluded that “the process . . . which these millions of [schizophrenics] go through in a way that's usually so very hazardous, isolated and uncreative, is nonetheless made up of the same stuff as seers, visionaries, cultural reformers and prophets go through” (in an interview conducted by O’Callaghan, 2001). In his own work directing Diabasis, a residential facility designed to support these individuals, “85 percent of the clients . . . not only improved, with no medication, but
most went on growing after leaving us” (Perry, 1999, p. 147). In his many decades of research and clinical experience in this domain, he arrived at a very interesting theoretical model for psychotic episodes (Perry, 1974, 1976, 1987, 1999), referring to them with the benign and hopeful term, the renewal process.

**Stages of the renewal process.** Perry (1999) came to the conclusion that an acute psychotic episode is not a result of damage or impairment, but is actually initiated intentionally by the unconscious psyche (although it is generally uninvited and most likely even unwelcome by the conscious mind of the individual). Perry said that “when a person finds herself in a state of acute distress, in circumstances that have assailed her most sensitive vulnerabilities, her psyche may be stirred into an imperative need to reorganize the Self” (p. 21). In other words, the psychotic episode is not the problem, but the attempt of the psyche to address a problem that existed prior to the episode—severe limitations of the personality. When one finds oneself to be living with a self-image and world-image that are unbearably limiting, the psyche initiates a profound reorganization.

During this shift, Perry believed that the deepest levels of the psyche are activated and draw a disproportionate amount of energy in the organismic system, leaving a very low level of energy available to the so-called higher functions (those responsible for relating to the external world). When this happens, the person finds that her field of awareness is flooded with archetypal affect-images, and often these very dramatic perceptions of one’s inner reality become confused with external reality. This confusion often leads to one of two persistent tendencies—identification and projection—the very tendencies that often provoke onlookers to perceive the individual as being so “crazy.” With identification, she may personally identify with the archetypal affect-images and
literally believe that she is, for example, the Virgin Mother or the Second Coming of Christ (Perry, 1999). This tends to happen with affect-images that are of a creative, or more desirable, quality. On the other hand, when the individual experiences archetypal affect-images of a destructive, or less desirable, quality, then she is likely to project these onto the external world, imagining herself to be the victim of CIA agents, malevolent aliens, or other powerful perpetrators. From this perspective, then, such identifications and projections are not manifestations of senseless madness, but are grounded in very real universal archetypes. The individual is merely overwhelmed and confused by these energies, and with time and the presence of other caring individuals who are validating and empathetic, this person is likely to move through this stage and integrate these experiences into a more, rather than less, accurate and helpful construct of the world and of the self.

An important aspect of the renewal process is that in order for such a profound reorganization of the Self to take place, a profound disintegration must first take place, followed by a thorough reintegration (Perry, 1999). During this process of disintegration and reintegration, one’s self-image and one’s world-image tend to go through a parallel process of dying to old ways of being and being reborn into new ways of being, a process that is rarely linear, often involving a variety of disintegration and reintegration experiences in a more or less unpredictable manner. During experiences of disintegration, one may literally believe that they have physically died or are on the verge of death. They may also have the sense that their very being is on the verge of succumbing to a total annihilation that is even more profound than physical death. This is often a very terrifying stage. During experiences of reintegration, one often has profound experiences
of “rebirth and of world regeneration” (p. 130). Often included within this stage are experiences of messianic affect-images, recognition of the unity of all things, and visions of a new world guided by compassion and love for all beings.

Perry discovered that most of those individuals he worked with who were suffering acute psychotic episodes and who were allowed to move through them in a supportive way worked through the process to resolution in about forty days. He found that this varied somewhat (with the length of time often being indirectly proportional to the intensity of the episode), but the variance was much less than he would have expected. This time period (forty days) has fascinating implications when one considers the frequency with which this same number is used to describe the transformative periods of historical prophets (of Esdras and Jesus in the Bible, and of the world-destruction of the deluge, for example).

**The goal of the process.** When the renewal process is allowed to move through to successful resolution, “a new sense of oneself appears along with fresh interests and motivations in the world” (Perry, 1999, p. 130). Throughout the process, “the motivations and capacities that lead to lovingness and compassion” (pp. 134-5) are stirred up, and upon resolution, these qualities become the core values which guide one’s life: “This may be experienced both as warmth and intimacy moving into one’s relationships, and also as a direct sense of the oneness of all beings—not just a belief or view of how things are, but as the actual experiential realization of it” (p. 135).

**Supportive therapy.** Perry (1999) suggested that when supporting a person going through a psychotic process, it is important to keep in mind that it is not the psychotic process from which one needs to be healed—this process itself represents an
attempt of the organism to heal itself from the limitations of the self-image and the
world-image of the person. Therefore, the best support we can offer is to support the
process itself, rather than try to suppress or reverse it; and the best way to support it is to
offer the individual our “clarita (clarity) and carita (caring)” (Perry, p. 80) above all else.
Perry’s use of the term clarity refers to our ability to be genuinely present with the
person, to offer our efforts to understand and support the person in finding meaning for
their experiences. In this regard, it is important to acknowledge that no amount of
education or training could ever put us in a position where we know more about the
meaning of the person’s experience or the experience that they need to have at any given
moment than their own psyche. Our job is simply to facilitate this process to the best of
our ability. Perry’s use of the term caring refers to our aspiration to hold the person and
all of their experiences, no matter how challenging they may be, with respect and
unconditional positive regard.

Implications for cultural reform. Perry (1999) pointed out that there is an aspect
of the renewal process that is crucial for the health of a society. Once an individual has
gone through a very profound reorganization of their inner culture, they sometimes
emerge with a vision of reorganization for the culture at large that is uncanny in its
timeliness and its effectiveness in bringing about just the reform that society needs in
order to continue its existence. Perry cited numerous examples of social visionaries and
reformers who have done exactly this. This observation, he said, suggests that “the
psychic healing process . . . does its work in two principal areas: on one side there is self-
healing in the individual persona’s renewal process, and on the other, cultural healing in
the visionary work of the prophet” (p. 106).
**Chronic schizophrenia.** Unfortunately, in our society, individuals going through such a process are very likely to be met with fear and invalidation, a response that Perry (1999) felt often has the effect of blocking this natural process and leaving the individual in a lost and confused condition indefinitely. In Western society, we generally go through extreme efforts to stop this process in an attempt to return the individual’s behavior and experiences to “normal” as quickly as possible. Yet Perry believed that this very attack on the psyche’s attempt to heal itself is one of the main reasons why there is such a poor recovery rate in the West, as compared to much more spiritually mature societies in which such visionaries are often met with validation, respect, and even honor (Whitaker, 2002). If this is indeed the case, then not only is it a very sad irony that our very attempt to support these individuals may actually be the main factor in preventing their recovery, but the implications this has for our society as a whole are also quite grave. In a time when our society is in desperate need of the guiding values of love, compassion, and wisdom, suppressing the very process that attempts to renew these values in wounded psyches and in our society at large could be very detrimental indeed.

**Process Oriented Psychology**

Mindell (2008) has developed a theoretical orientation he calls *Process Oriented Psychology* (which he also refers to as the *process paradigm*), a model based particularly on concepts from Jung’s work and on various field and systems theories. Mindell’s model provides a unique and interesting perspective from which to look at the phenomena of psychotic and mystical states, to which he collectively refers as simply *extreme states*. I will first briefly describe each of the most essential relevant concepts of Mindell’s model.
and then bring them into a more complete description of how extreme states are understood from this perspective.

**Primary and secondary processes.** The core principle in the process paradigm is that all of us have both *primary processes* and *secondary processes* operating within us all of the time. The primary process is the process within our psyche with which we are presently the most identified. The secondary processes are those within our psyche with which we are the least identified, and of which we are most likely not even fully conscious (these are closely correlated with Jung’s term, *the shadow*).

**The feedback loop.** The *feedback loop* refers to our ability to take in information from the external environment so that we may modify our own behavior and beliefs accordingly. Mindell (2008) suggested that all of us have filters acting on our feedback loop, to a greater or lesser degree, and that all of us have significant blind spots in our perceptions of the world that often serve us in minimizing information that might be painful and/or difficult to integrate into our personal worldview.

**The metacommunicator.** *Metacommunication* simple means “communicating about some aspect of communication” (Mindell, 2008, p. 59); and a *metacommunicator*, then, is that aspect of ourselves that is able to remain somewhat detached from our experience and comment on what we are communicating, expressing, feeling, thinking, etc. This is closely correlated with the concept of an observing ego discussed above. Mindell (2008) suggested that all of us have access to a metacommunicator, but that that access can fluctuate dramatically, even in so-called normal people. For example, many of us find it difficult to access our metacommunicator during states of strong fear or anger.
**Difference between “normal” states and extreme states.** When we perceive someone as crazy or as a schizophrenic, what exactly are the qualities that lead us to make this distinction? Mindell (2008) suggested that there are three main differences between being in an extreme state and being in a normal state, and that these differences manifest in behavior that is often observable to onlookers.

One difference is that, in an extreme state, the feedback loop is very limited or even nonexistent. By blocking the feedback loop, the individual is able to completely “filter out signals which oppose his belief in order to preserve and complete the inner story or myth he is working on” (Mindell, 2008, p. 56). To an outside observer, this gives the appearance of inappropriate affect; however, whereas it may be true that the individual’s affect is inappropriate relative to the external situation, it is likely very appropriate to what is going on internally. Mindell (2008) pointed out that one irony we often find in the mental health care system is a therapist who is suffering from a similarly poor feedback loop when she insists that the client is psychologically disordered in spite of the client insisting otherwise.

A strongly limited or missing feedback loop is a necessary condition for extreme states, but is not sufficient by itself. The second necessary factor is that the metacommunicator is very weak or even temporarily nonexistent. Whereas a normal person occasionally goes through periods of limited or even no metacommunication (such as when angry, fearful, etc.), someone we label as psychotic goes through much more extended periods without metacommunication (Mindell, 2008). Without a metacommunicator, the primary and secondary processes are free to rapidly change places (what Mindell refers to as *flipping*) or to even superimpose upon one another,
giving the appearance that the individual’s personality has suddenly and dramatically changed and/or is highly unstable. Mindell suggested that we all have the potential to flip, given that we all have primary and secondary processes, but that our metacommunicator generally does not allow this to happen. This could explain why even “normal people can go through dramatic personality changes during times when their metacommunicator is particularly weak, such as when intoxicated with alcohol or drugs or when overwhelmed by strong emotions.

The third factor necessary for the onset of an extreme state is the presence of a strong conflict between the primary and secondary processes. When in an ordinary state, we often have some sense that there is a conflict going on within us. In fact it is this very awareness, according to Mindell (2008), that causes suffering. In a so-called mentally healthy individual, the awareness of these various processes is there, but the conflict between them is minimal. In a so-called neurotic individual, the awareness is also there, but the conflict is stronger. An individual in whom this inner conflict is particularly severe, and who has been too successful in avoiding the painful confrontation between these different processes, is particularly susceptible to flipping into an extreme state. Mindell remarked, “If we do not learn to follow these processes, then nature does it for us by producing experiences such as schizophrenia” (p. 95).

**Therapy for an individual suffering extreme states.** Since, according to the process paradigm, the fundamental problem underlying extreme states is a severe lack of integration between an individual’s primary and secondary processes, therapy naturally consists of facilitating this integration (Mindell, 2008). The principle is the same whether working with an individual suffering from more ordinary neurotic conflicts as it is with
someone struggling with extreme states—the therapist attempts to facilitate the deepening of the individual’s awareness of these various processes within themselves and the working through of the pain and conflict as these processes integrate and transform each other. However, since extreme states are of course more extreme than neurotic states, the therapeutic intervention also needs to be somewhat more extreme, and it is often helpful to apply some of the principles derived from occupation theory.

Occupation theory says that in any polarized system (whether it is comprised of different individuals or of different aspects of one individual’s psyche), the entity whose quality is most similar to one pole will occupy that position, and the same principle applies for all of the remaining entities and poles (Mindell, 2008). For example, if one member of a group tends to be subservient in other systems, but is actually the most dominant in this particular group, he or she will tend to occupy the dominant role. The same can be said for various aspects of our psyche. According to the process paradigm, the extreme state is nearly always a highly polarized system (between the primary and secondary processes). If the therapist is able to take on the dominant quality of the process of the client which is dominant during an extreme state (the apparently crazy process) even more strongly than the client, then the client will naturally flip back, and their original (apparently sane) primary process will naturally surface. In this way, both processes involved in the conflict that brought on the extreme state can be directly contacted and worked with.

Successful resolution, then, entails the integration of these two processes, which is most often followed by other processes and conflicts that more closely resemble neurotic conflicts dealt with in more ordinary therapy (Mindell, 2008). During the therapeutic
process, it is important to remember that “the process paradigm does not consider a symptom something to overcome, but an aspect of the personality in need of integration” (Mindell, 2008, pp. 111-12). Therefore, the client is often encouraged to go more deeply into the experiences often referred to as *symptoms* in order to facilitate integration.

**Benefits of extreme states for society.** Like Perry (1999), Mindell (2008) suggested that extreme states play a very important role in maintaining the health of a society. Mindell suggested that the world can be seen as operating like a field that (1) has its own awareness, and (2) “does everything it can to bring itself to consciousness” (p. 60). In psychotic people, in whom the metacommunicator is weak or temporarily nonexistent, the field finds a channel (the psychotic person) with which to express itself to the rest of the world:

> The field thus informs the general public about its conflicts. This can be formulated in different ways, depending upon belief systems. One might say that the Self wants to know itself, or that God is trying to discover himself, the Anthropos we are living in is trying to wake up, the collective unconscious is trying to express itself or the universe is evolving in such a way as to make us more aware of the meaning of life. (p. 61)

The process paradigm offers us a particularly useful model for understanding the oft-observed irony that society tends to view an individual immersed in an extreme state as ill, while that individual tends, simultaneously, to view society as ill. According to the process paradigm, each represents the shadow (the secondary process) of the other. Mindell (2008) wrote:

> In a given collective, the schizophrenic patient occupies the part of the system in a family and culture which is not taken up by anyone else. She occupies the unoccupied seat at the Round Table, so to speak, in order to have every seat filled. She is the collective’s dream, their compensation, secondary process and irritation. (p. 125)
An Evolutionary Imperative

House (2001) contributed a perspective that is similar to both Perry’s (1999) and Mindell’s (2008) in that he draws substantially from Jung’s work and emphasized the importance of visionary experiences in cultural and consciousness evolution. He does bring in what is perhaps a somewhat more radical twist in this perspective than either Perry or Mindell, and so I believe his perspective deserves a brief mention.

House (2001) believed that in the current era of Western society, with its “scientism, materialism, ‘control freakery,’ and narcissism” (p. 119), human consciousness has become severely imbalanced in the direction of ego development, and he suggested that this may be why we in Western society have so much more difficulty containing psychosis with its accompanying ego loss than those in more collectivistic third-world countries. In a radical departure from mainstream thinking, House suggested that “perhaps those who do experience such (often deeply distressing) ego-loss—for whatever reason and in whatever circumstances—are experiencing a crucial species-wide evolutionary imperative from which we must be open to learning [author’s emphasis]” (p. 119). In other words, perhaps those suffering from these types of experiences are leading the way, albeit often unintentionally and haphazardly, for the rest of us in a much needed shift away from our extreme emphasis on ego and individuality.

Seeing Through the Veil of our Cognitive Constructs

I will now shift to a more cognitive perspective in the next two models that I present. Clarke (2001) is both a researcher and a clinician with extensive experience working with people suffering with psychosis. She believes that the distinction between mystical and psychotic experiences is only superficial, that most experiences from both
of these categories arise from the same underlying process; therefore, she prefers to use the single term *transliminal* to capture all of these types of experiences.

Clarke (2001) argued that psychosis, spiritual experiences, and even social movements such as revolutions arise from a common process that involves a shift or discontinuity in consciousness. She combined her own discoveries with the discoveries of a number of other researchers and clinicians to formulate a model that described the cognitive mechanism behind this shift and the associated transliminal experiences. Among the research from which she drew in the formulation of this model were Chadwick’s (1992, 2001) study of his own psychotic experience, Frith’s (1979) research into the failure of cognitive systems that filter information from consciousness in people experiencing psychosis, Hemsley’s (1998) research into the disruption of the “sense of self” in those who experience psychosis, and Teasdale’s interacting cognitive subsystem model (Teasdale & Barnard, 1993).

In Clarke’s model, she illustrated two key cognitive subsystems that we all have. The first is the *propositional subsystem*, which represents our logical mind and is capable of fine discrimination. The memory of experiences related to this subsystem is stored verbally. The second is the *implicational subsystem*, which represents holistic perception and emotional meaning. The memory of experiences related to this subsystem is stored via sensory modalities. Clarke (2001) suggested that in everyday functioning, these two systems are in relative balance, but in transliminal experiences, the implicational subsystem is primarily running the show. When the implicational subsystem is dominant, we experience the world in relatively undifferentiated wholes and are unable to manage fine discrimination; our experience is emotionally charged, often swinging sharply
between euphoria and terror, and we find ourselves particularly concerned with the self and threats to the self. In other words, when we are experiencing the world primarily through the implicational subsystem, we are actually peering through the veil of our discriminating constructs to some degree and experiencing the world in its more raw form.

Clarke (2001) suggested that the primary difference between what are often considered mystical experiences and psychotic experiences is that in mystical experiences, a return to balance occurs naturally and relatively quickly, generally leading the individual to feel more integrated than before the experience; in psychotic experiences, on the other hand, the orderly return does not happen in such a timely manner, and even when a return happens, the individual often feels destabilized and is easily susceptible to more ungrounding transliminal experiences: “For the person with psychosis, the barrier that makes this sort of experience hard to access for most of us is dangerously loose” (p. 137). Clarke agreed with other writers such as Chadwick (1992) and Laing (1967) that it is one’s ego strength (the solid establishment of a sense of self) that “will predict whether [a transliminal experience] is a temporary, life enhancing, spiritual event, or a damaging psychotic breakdown, from which there is no easy escape” (p. 139).

Clarke (2001) felt that transliminal experiences are natural and even essential for a healthy society, but that Western society, in its drive for the material and the graspable, has marginalized ungraspable transliminal experiences and with this marginalization, it has lost its sense of interconnectedness and comfort with mystery and the unknowable. She suggested that the original role of religion and spirituality has been to keep us
connected with this holistic, mysterious, interconnected realm. However, by concentrating on the fate of the individual soul rather than our interconnectedness with a greater whole, she feels that our modern religions have let us down, allowing “the technology born of our ferocious power to discriminate and to bend the material world to our will [take us to] the point where the sustainability of our species is put in question” (p. 142). Clarke suggested that “without in any way failing to recognize the suffering associated with psychosis, we could respect the experience of those suffering in this way for its connection with the sacred state” (p. 142).

**The Creative Process Gone Awry**

Jackson (2001) conducted a qualitative multiple case study involving 18 participants in an attempt to explore the relationship between benign spiritual experiences and psychosis. The participants were separated into two groups—those who were diagnosed with a psychotic disorder in one group and those who were undiagnosed and seemed to have experienced benign spiritual experiences in the other. In summary, Jackson came to the conclusion that participants in both groups had gone through or were going through a similar “basic, adaptive psychological process, which is also observed in artistic and scientific creativity” (p. 185). Jackson discovered that a model developed by Batson and Ventis (1982) (which drew from the original work of Wallas, 1926), fit the findings of his study very well.

This model describes the cognitive processes underlying creative thinking as taking place in four steps, the summary of which follows:
1. **Preparation and impasse:** First, one becomes aware of a problem and tries to solve it using normal problem-solving strategies, but eventually, finding it impossible to make further progress, arrives at an impasse.

2. **Incubation:** The impasse creates cognitive and/or emotional tension, leading to conscious withdrawal from the problem and a period of incubation.

3. **Illumination:** At some point, a solution suddenly emerges from the unconscious, resolving the impasse, typically by means of a personal paradigm shift. The illumination often appears nonverbally, and is often felt to have originated from an external source.

4. **Verification:** The illumination is formulated in rational terms, and its validity is tested empirically. Upon verification, the original cognitive/emotional tension that initiated the process is finally released.

This process corresponds with the epiphanic “Aha!” experience to which probably most of us can relate.

Batson and Ventis (1982) have suggested that mystical experiences involve this same process, but that they involve existential rather than intellectual problems, typically much higher levels of emotional tension along with cognitive tension, and solutions that involve metaphysical rather than theoretical paradigm shifts. Jackson (2001) added to Batson and Ventis’s model by suggesting that psychotic experiences can also be the result of this very same process.

Jackson (2001) suggested that both mystical and psychotic experiences begin with the same underlying intention of finding a solution to an existential problem, but that in the case of a mystical experience, the process resolves successfully, whereas in the case
of a psychotic experience, the process does not resolve successfully. In the case of a mystical experience, we can see the process as acting like a negative feedback loop: significant tension is generated along with a sense of crisis; a necessary shift in the individual’s paradigmatic framework subsequently takes place; the tension and sense of crisis fade; and the feedback loop is completed. A psychotic experience, on the other hand, can be seen as a positive feedback loop: upon generation of tension and a sense of crisis, a paradigm shift takes place, but for some reason this shift fails to resolve the tension and may even inadvertently increase the tension. This leads to another unsuccessful paradigm shift, leading to even further tension and the potential for an ever worsening spiral of chaotic paradigm shifts and eventually florid psychosis.

This concept corresponds well to what is often seen in acute psychosis, when belief systems and emotional states often change and alternate very rapidly. Jackson (2001) suggested that one possible reason for the lack of successful resolution in the case of psychosis is that the new belief system itself may be highly distressful (such as in the case of persecutory delusions) or the new paradigm may have validity, but if it does not conform to consensus reality within an intolerant society, harm to the individual’s relationships with others and/or harm to the individual’s confidence in his or her sanity may lead to increased distress.

A final point of clarification in this model is that the underlying process is considered to be healthy, adaptive and actually an essential part of navigating through the world. According to Jackson (2001), it is only in a small minority of cases that this process fails and we see the manifestation of psychotic experiences.
Otto Rank’s Life-Fear/Death-Fear Dialectic

The final models of psychosis I will present in this section have been formulated by more explicitly existentially-oriented thinkers (Yalom, 1980; May, 1977; Becker, 1973). Before I present their models, however, it will help to first present Rank’s life-fear/death-fear dialectic. Rank, who was a protégé of Freud for nearly 30 years before breaking away and forming many of his own alternative ideas in the late 1920’s, did not offer a particularly coherent system for understanding psychosis. However, he formulated a model of a core existential dilemma that would eventually become an important foundation for the work of these and other existentially-oriented thinkers.

In 1934, Rank published Will Therapy, in which he first introduced his idea that at the core of all fear is a dynamic dialectical system comprised of two poles (see Figure 1). At one pole lies what Rank referred to as life fear, which he defined as “the fear of having to live as an isolated individual” (p. 124), or in other words, the fear of isolation and of being cut off from the source of life. At the other pole lies what Rank referred to

![Figure 1](image.png)

*Figure 1.* A graphical depiction of Rank’s life fear vs. death fear dialectic.
as death fear, which he defined as “the fear of the loss of individuality” (p. 124), or in other words, the fear of being engulfed by too much merger and connection. Rank suggested that, as we move through life, we find ourselves perpetually striving towards one side or the other as we seek to find some tolerable middle ground. We respond to the life fear by moving towards deeper merger and connection; but as we do so, we find that we begin to lose our sense of self and are faced with the threat of self-annihilation (death fear). Then, as we respond to death fear and move towards life and individuation, we become further isolated from our connection with the world and the source of life (life fear), and once again find ourselves compelled to move back in the direction of merger and connection.

**Overwhelmed by Death Anxiety**

Nearly half a century later after Rank formulated his life-fear/death-fear dialectic, Yalom (1980) formulated his own model of psychopathology and psychosis that has some significant overlaps. In it, he suggested that “death…is the primordial fount of psychopathology” (p. 29). He suggested that all humans struggle to a greater or lesser extent with the fear of death, even though this struggle is predominantly unconscious for most of us. When one’s strategies are not entirely adequate in addressing this fear, then one is vulnerable to experiencing various neuroses; and when one is completely overwhelmed by this fear, then one is vulnerable to psychosis. In order to give a coherent account of how Yalom believes psychosis may occur in this regard, it will be helpful to first give a brief description of his model that details his understanding of how all of us (regardless of our degree of contact with consensus reality) deal with death anxiety.
Defining death anxiety. Yalom (1980) noted that many different definitions for the fear of death have been posited, including Jaspers’ fragility of being, Kierkegaard’s dread of non-being, Heidegger’s impossibility of further possibility, and Tillich’s ontological anxiety (cited in Yalom, p. 42). He believed that it is difficult to come to an umbrella definition that includes all of these variations since we all experience the fear of death a little differently. Ultimately, he established a preference for defining the fear of death as the fear of “‘ceasing to be’ (obliteration, extinction, annihilation)” (p. 43). He also made the point to draw a distinction between fear and anxiety. He borrowed Kierkegaard’s (1844/1967) distinction, defining fear as the fear of some thing whereas anxiety or dread is the fear of no thing. In raw anxiety, one experiences the dread of losing oneself, of becoming nothingness. Since no object of this anxiety can be found, we feel utterly helpless in the face of it, and so the anxiety becomes even more overwhelming. With this distinction in mind, Yalom believed it is more accurate to use the term death anxiety than to say that we have a fear of death.

Coping with death anxiety: Two instinctive methods. Yalom (1980) believed that from very early childhood, we begin coping with death anxiety using primarily the strategy of denial. He believed that this denial is generally facilitated by two core beliefs: (a) we are “personally inviolable” (p. 112), and/or (b) we are “protected eternally by an ultimate rescuer” (p. 112). While most of us use some combination of both of these delusional beliefs, clinical evidence shows that in some unusual cases, an individual may rely almost entirely on one or the other.

The belief in one’s specialness. It is likely that most of us who have performed any deep and honest introspection would admit that we believe there is something a little
bit special about us, that we are personally inviolable in some way. On a rational level, we admit that of course we will die just like anyone else. But deep down, there is a feeling that death and other such horrible things only happen to others. This delusional belief is what Yalom (1980) referred to as *specialness*. Of course, we are all doomed to have the falsity of this belief come crashing down on us one day; yet in the meantime, it does provide us with a very effective strategy for coping with death anxiety. This belief in one’s specialness can manifest in different ways in different individuals, ranging from relatively benign manifestations to severely maladaptive ones, depending upon the desperation with which one holds it.

The strategy of specialness often manifests in the pursuit of heroism. In its more benign form, we find a relatively healthy individual who cultivates qualities such as courage, self-reliance, and a sense of adventure. But as this strategy becomes more extreme, we find what Yalom called the compulsive hero. A compulsive hero is someone who must “seek out and conquer danger as a grotesque way of proving there was no danger” (1980, p. 122). Yalom used Hemingway’s life as an example in which this strategy became so extreme that it eventually led to psychosis. Hemingway’s mother said that the first words he spoke as a child were, “‘fraid of nothing”; and Yalom pointed out that the irony in this attitude is that one tries to convince oneself that they are afraid of nothing precisely because they are afraid of nothing—*nothingness*, that is. As Hemingway grew older, because he had clung so tightly to his myth of personal inviolability, as the inevitable happened and this myth began to unravel, he completely fell apart. He first fell into deep depression, then into paranoid psychosis, and finally he took his own life.
Other forms that the strategy of specialness takes is workaholism, in which one attempts to prop up their belief in specialness by believing that they are constantly progressing or getting ahead; narcissism, which results when “a belief in personal inviolability is coupled, as it often is, with a corresponding diminished recognition of the rights and the specialness of the other” (p. 125); and the drive for power, whereby one attempts to “enlarge oneself and one’s sphere of control” (p. 127) as a reaction formation against one’s own sense of insecurity and limitation.

**The belief in an ultimate rescuer.** With the strategy of believing in one’s specialness, the individual attempts to separate and individuate; however, with the strategy of believing in an ultimate rescuer, the individual takes the opposite approach and attempts to merge or fuse with another (Yalom, 1980). The manifestations of this strategy are somewhat less diverse than those of the strategy of specialness—essentially, there is simply a belief in a supreme immortal other in whom we can merge and therefore defy our own mortality. This other may take the form of a supernatural figure such as a god or a goddess; or it may take the form of a country, a leader, or even a cause or value system. Yalom believed that, overall, this strategy is less effective than the specialness strategy, and he has cited empirical research to support this conclusion. In attempting to merge with another, Yalom pointed out that this strategy ultimately leads one directly into that which it is attempting to avoid—the loss of oneself (i.e., existential death). This strategy leads to the failure to explore one’s potentialities, the failure to self-actualize, and it generally results in living a highly limited and unstable life.

**A framework for understanding psychopathology and psychosis.** While the strategy of the belief in one’s specialness and the strategy of the belief in an ultimate
rescuer are clearly very different, Yalom (1980) suggested that the majority of us probably use both of these to some degree: “Generally one does not construct a single ponderous defense but instead uses multiple, interlaced defenses in an attempt to wall off [death] anxiety” (p. 141). He pointed out that rather than being mutually exclusive, these two modes of defense are actually complementary:

Because we have an observing, omnipotent being or force continuously concerned with our welfare, we are unique and immortal and have the courage to emerge from embeddedness. Because we are unique and special beings, special forces in the universe are concerned with us. Though our ultimate rescuer is omnipotent, he is at the same time, our eternal servant. (p. 141)

Yalom went on to suggest that because of the interplay between these two belief systems, we find ourselves torn between two opposing fears in a dynamic dialectic that closely parallels Rank’s life-fear/death-fear dialectic:

“Life anxiety” [which corresponds to Rank’s life fear] emerges from the defense of specialness: it is the price one pays for standing out, unshielded, from nature. “Death anxiety” [which corresponds to Rank’s death fear] is the toll of fusion: when one gives up autonomy, one loses oneself and suffers a type of death. Thus one oscillates, one goes in one direction until the anxiety outweighs the relief of the defense, and then one moves in the other direction. (p. 142)

Similar to Rank’s thinking, then, Yalom suggested that we find ourselves caught in a perpetual oscillation between these two fears, and each of us develops a unique and complex set of strategies in an attempt to mitigate these fears and find some tolerable middle ground. Yalom suggested that it is in our navigation of this dialectic that a framework for explaining psychopathology can be found. He suggested that a neurotic is one who clings especially tightly to either one or the other of these two strategy systems (the belief in one’s specialness or the belief in an ultimate rescuer). This causes them to live a very restricted life, and they subsequently become plagued by existential guilt—guilt arising not from a transgression to another but from a transgression to oneself, in
failing to live a full, authentic life. A psychotic on the other hand, is one who is so tormented by death anxiety (perhaps because of overwhelming exposure to it at a young, vulnerable age, or because of serious attachment issues with the caretaker as an infant) that she or he clings even more desperately to defensive strategies than does the neurotic. Such clinging is not only more desperate, but is also much less secure and stable. The psychotic individual may swing dramatically from a sense of extreme specialness (omnipotence and/or compulsive heroic striving) to a sense of extreme merger and loss of boundaries.

**When Overwhelming Anxiety is Insoluble on any Other Level**

Like Yalom, May (1977) also used Rank’s work as an important foundation for his own formulation of psychopathology and psychosis. May came to believe that “many forms of psychosis are to be understood as the end result of conflicts and anxiety which are too great for the individual to bear and at the same time insoluble on any other level” (p. 326). To more fully understand what May meant, it is important to look more closely at what he means by “conflicts and anxiety.”

**Defining anxiety.** May spent a great deal of time grappling with the definition and meaning of anxiety, even devoting an entire book to the subject (1977). He, like Yalom (1980), drew from Kierkegaard’s (1844/1967) distinction between fear and anxiety, saying that fear is a sense of apprehension in relation to a specific object while anxiety is a vague and apparently “objectless” apprehension, involving a general sense of uncertainty and helplessness (May, 1977, p. 205). May suggested that a useful approach to understanding the essential nature of anxiety is not to focus so much on the quality of anxiety but to instead ask what it is in our experience that is being threatened. He
suggested that fear typically involves a threat to something relatively superficial in our experience (such as physical harm), while anxiety represents a threat towards the core of our personality. In other words, the particular fear that someone experiences is based on the individual’s particular security pattern; in anxiety, however, “it is this security pattern itself which is threatened” (p. 206). May (1977) offered the following formal definition of anxiety:

Anxiety is the apprehension cued off by a threat to some value that the individual holds essential to his existence as a personality. The threat may be to physical life (the threat of death), or to psychological existence (the loss of freedom, meaninglessness). Or the threat may be to some other value which one identifies with one’s existence: (patriotism, the love of another person, “success,” etc.). (pp. 205-6)

The real challenge in working with anxiety is that since it is the very core of our sense of self that is being threatened, there is no way to stand outside of it—there is no object to confront. When experiencing anxiety, we find that the very structure that maintains a sense of I as separate from the world is under threat. Extending May’s discussion a little further, I find that a real paradox arises here: Since it is presumably the I that has the agency to deal with threats, and since it is the very I that is being threatened, when experiencing anxiety, it is likely that we also experience the sense that our very agency could come crumbling down along with the I at any moment. Perhaps the potential to feel such profound feelings of helplessness in anxiety arises from the combination of having no object to confront and sensing a threat to our very capacity to confront anything.

Normal and neurotic anxiety. May (1977) proposed that anxiety can be divided into two categories: normal anxiety and neurotic anxiety. Normal anxiety is (a) proportionate to the degree of threat, (b) does not involve intrapsychic conflict such as
repression or neurotic defenses, and (c) can either be dealt with constructively or it naturally leaves once the threat is lifted. With neurotic anxiety, the opposite is true with regard to all of these qualities. The crucial distinction is that with neurotic anxiety, there are intrapsychic conflicts and patterns that interfere with our ability to maintain a clear evaluation of the situation and to use our own power effectively. May (1977) suggested that neurotic anxiety usually has its genesis in childhood, being especially likely to develop when a child finds she must resort to repressing the awareness of a potentially overwhelming interpersonal threat. For children, the quality of their relationship with their caregiver(s) is a key factor in their core sense of security; therefore, children are particularly vulnerable to being traumatized by the kinds of threats that cause anxiety within these relationships, and their level of anxiety can easily escalate from normal to neurotic.

The intrapsychic conflicts within anxiety. As mentioned above, a fundamental distinction between normal and neurotic anxiety is that neurotic anxiety contains intrapsychic conflicts. It is important to note, however, that May (1977) held that neurotic anxiety arises directly out of normal anxiety. According to May, we all enter life experiencing normal anxiety, and difficult circumstances lead to the exaggeration of this normal anxiety until we experience neurotic anxiety. While some experience more neurotic anxiety than others, none of us are completely free from it. So, the intrapsychic conflicts that are more evident in neurotic anxiety have their roots in a more subtle form in normal anxiety. May (1977) suggested that while the particulars of these conflicts may vary significantly, they all share one common root—“the dialectical relation of the individual and his community” [author’s emphasis]” (p. 228). On one hand, the individual
possesses a strong need to individuate, to find one’s uniqueness, one’s authenticity, one’s sense of agency. On the other hand, the individual possesses a strong need to be a member of a community, to experience love and belonging.

These two directions of development can be seen as two poles, and according to May, if either pole becomes blocked, psychological conflict and therefore neurotic anxiety results. An individual who develops an imbalanced emphasis on the independence pole develops “the anxiety of the defiant and isolated individual” (p. 228); an individual who develops an imbalanced emphasis on the dependence pole develops “the anxiety of the clinging person who cannot live outside of symbiosis” (p. 228). Along with these imbalances develop conflict systems comprised of hostility and repression. Those individuals imbalanced in the direction of independence develop hostility toward those believed to be responsible for the individual’s isolation and those individuals imbalanced in the direction of dependence develop hostility toward those believed to suppress the individual’s freedom. As these hostilities develop, they are often repressed (due to the feared consequences of expressing them), completing what can be a very entrenched system of intrapsychic conflict and neurotic anxiety.

It is easy to see that May’s formulation of psychopathology is closely related to Rank’s life-fear/death-fear dialectic, and in fact, May (1977) openly acknowledges the role that Rank’s work in this regard has influenced his own.

**The development of psychosis.** So, May suggested that all psychogenetic psychopathology arises ultimately from intrapsychic conflicts stemming from the unsuccessful resolution of finding both a healthy sense of individuality and a healthy sense of community and relationship. May (1977) then went on to suggest that if these
conflicts and associated anxiety become too great for the individual to tolerate “and are insoluble on any other level” (p. 326), then psychosis is likely to ensue. In other words, May (1977) suggested that psychosis is nothing more nor less than the means with which the psyche attempts to “[obviate] otherwise insoluble conflicts and anxiety, at the price…of the surrender of some aspect of adjustment to reality” (p. 326).

**Overwhelming Exposure to the True Nature of the World**

Like Yalom and May, Becker also gives Rank credit for providing an important foundation for his own work, though his own formulation of psychopathology does not map onto Rank’s model quite as cleanly as does that of Yalom and May. What lies at the heart of Becker’s work is that the fear of death is the fundamental dilemma giving shape to all the other challenges in our lives, including all forms of psychopathology and psychosis. He says, “we might call this existential paradox the condition of *individuality within finitude*”...

Man has a symbolic identity that brings him sharply out of nature. He is a symbolic self, a creature with a name, a life history. He is a creator with a mind that soars out to speculate about atoms and infinity. . . . This immense expansion, this dexterity, this ethereality, this self-consciousness gives to man literally the status of a small god in nature, as the Renaissance thinkers knew. Yet, at the same time, as the Eastern sages also knew, man is a worm and food for worms. This is the paradox: he is out of nature and hopelessly lost in it; he is dual, up in the stars and yet housed in a heart-pumping, breath-gasping body that once belonged to a fish...” (1973, p. 26)

In other words, human beings have the capacity to experience themselves as existing in something like an eternal presence, savoring the sweet illusion of omnipotence and omnipresence (our symbolic self), yet are trapped in a body that is doomed to decay and die. We find ourselves torn between our seemingly eternal symbolic identity and our impermanent physical body. Becker suggested that this dilemma, though it is generally
repressed and unconscious, is the essential motivating factor that drives us through our lives.

Many would argue at this point that if this dilemma were so essential to our experience, we would certainly be more conscious of it. In response to this, Becker (1973) suggested that while the fear of our own mortality must be present enough to ensure self-preservation, if we were constantly aware of this fear, especially of the full scope of it, we would be so overwhelmed, we would be unable to function. Therefore, it is essential to our own sanity that we find some way to mitigate this fear, and in fact, he has suggested that psychosis is a result of being unsuccessful in our mitigation of this fear. To better understand how this may occur, it will help to first understand the process of successful mitigation, which Becker said we do using two primary strategies: the development of our character structure and our perpetual striving towards heroism.

**The vital lie of character.** Residing at the foundation of our defense against the fear of death is what Becker (1973) referred to as the *vital lie of character.* As the illusion of omnipotence that is believed to have filled our experience during our first year of life begins to fade, we find ourselves living in a world at once so awesome, terrifying, and incomprehensible, that if we did not limit, distort, and repress our perceptions, we would be overwhelmed and unable to function. We would be overwhelmed not only by external stimuli but also by the thoughts and feelings emanating from within—especially those that make us feel weak, shameful, worthless, and evil. In response to this, we begin to learn at a very early age how to repress our experience on a global level in an attempt to create a “warm sense of inner value and basic security” (1973, p. 52). Becker argued that other animals are given automatic instinctive programming as the means to achieve this,
but we humans have to do the arduous work of constructing our own defensive system—our character structure. This character structure, while providing us with the illusion of security and value, also limits our freedom and expansiveness, and therefore puts us in a very painful dilemma: “Our deepest need is to be free of the anxiety of death and annihilation; but it is life itself which awakens it, and so we must shrink from being fully alive” (1973, p. 66). We find ourselves in the unfortunate situation of being both afraid to die and afraid to really live; but, according to Becker, this is the high price we must pay for being human.

**Heroic striving.** Becker (1973) believed that a second line of defense against our fear of mortality is provided by our perpetual striving towards heroism. In order to fight against the apparent worthlessness and disposability of our physical body, we must “desperately justify [ourselves] as an object of primary value in the universe; [we] must stand out, be a hero, make the biggest possible contribution to world life, show that [we count] more than anything or anyone else” (p. 4). This stance is apparent in the overt narcissistic demands of young children. That this behavior fades away as we grow into “healthy” adulthood is not a sign that we have fundamentally overcome this stance, but rather it means that, for most of us, we have simply learned to transform our individual heroic strivings into social heroic strivings.

Becker (1973) argued that the ultimate function of society is in fact to provide us with the means to negotiate the transcendence of our death, to provide us with immortality projects. He described society as a “symbolic action system, a structure of statuses and roles, customs and rules for behavior, designed to serve as a vehicle for earthly heroism” (p. 4). In this view, cultural differences are merely differences of hero-
Regardless of whether a particular system is considered magical, spiritual, scientific, or civilized, the role is the same: to provide us with a feeling of “primary value, of cosmic specialness, of ultimate usefulness to creation, of unshakable meaning” (p. 5). Even if a society fails to provide this adequately for us, most of us are adept at finding it in other ways—for example, through our family, our work, our goals, or our values—and most of us are able to find more than one avenue for achieving a sense of death transcendence. With more passionate individuals, such as many successful politicians, business professionals, athletes, and even spiritual leaders, such heroic strivings are obvious. In more passive individuals, such strivings are not so obvious but can still be seen manifesting in safer, more mundane ways such as pride in one’s profession or the drive to receive recognition for smaller things.

Our striving for heroism, according to Becker (1973), results in a very harmful irony: While our heroic strivings are rooted in our desire to transcend death, and are therefore aimed at destroying evil (which, by definition, is the intentional causing of harm, destruction, and death), such strivings paradoxically generate more evil in the world. Because we each cling so tightly to our own hero-system, depending desperately on the righteousness of our own system to prop up our fragile illusion of death transcendence, we respond to any other hero-system that contradicts our own as a serious mortal threat. As a result, we see these other systems (be they societies, religions, governments, different value systems, etc.) as evil. We justify attempts to annihilate them, and as a result, we end up with a world that is plagued by hatred, war, and violence.
Implications for psychosis. Becker (1973) said that psychopathology is simply “a way of talking about people who have lost courage, which is the same as saying that it reflects the failure of heroism” (p. 209). He described a neurotic as someone who has particularly strong awareness of his “creatureliness” (p. 94), of his physical, mortal self; a neurotic’s attempt to construct the illusion of immortality, to develop a high sense of self worth, to attain heroic status, has been particularly weak. A psychotic, then, falls further along this same spectrum.

Due presumably to a particularly traumatic upbringing and/or other unfortunate circumstances, a psychotic individual is one who was unable to develop either a secure seating in their body or a secure connection with their culture’s hero-system, and therefore is unable to successfully deny the world and the terror of it. Ironically, then, the psychotic is in a position to witness the true nature of the world more accurately than the so-called mentally healthy individual, although they are likely to be completely confused and overwhelmed by what they witness. Therefore, they must rely “instead on a hypermagnification of mental processes to try to secure death-transcendence; [they have] to try to be a hero almost entirely ideationally” (Becker, 1973, p. 219). Since this is a poor substitute for the buffers of the mentally healthy individual, we see desperate strategies such as “megalomanic self-inflation” and fabrications of “new symbolic transcendence” (Becker, 1973, p. 220).

Toward a Paradigm Shift in the Way We View Personal Paradigm Shifts

As discussed earlier, I believe that the models presented above are among the most compatible with the existing research and while the details of each of them vary significantly from the others, they are not necessarily mutually exclusive since they each
emphasize different aspects and/or different perspectives of the psychotic experience. It is also important to notice that they all share as a fundamental postulate the idea that psychosis is a natural process initiated by the psyche and that it is closely associated with a profound reorganization of one’s personal paradigm.

So, after distilling the most significant research related to the topic of long-term psychosis and recovery, and after looking at some theoretical models that seem to fit this research well, we find that several interesting shifts happen in the paradigmatic framework with which this topic is ordinarily held:

First, contrary to the assumptions made by many of the transpersonally-oriented researchers, we find that making a distinction between the categories of psychotic and mystical experiences becomes less relevant and perhaps even ultimately impossible. House (2001) suggested that “the distinctions between ‘psychotic,’ ‘unusual’ and ‘mystical/transpersonal’ experience are not only far from clear-cut, but might well be fundamentally misguided and philosophically unsustainable” (p. 109). Clarke (2001) argued that making an “absolute distinction is invalid and essentially meaningless. . . . The relationship between psychosis and spiritual experience does not fit into this type of neat dichotomy” (p. 140).

Second, we find a significant change in the implications of how we can best support people going through such experiences. As mentioned previously, many transpersonally-oriented therapists have suggested that those who are experiencing psychotic experiences should receive standard psychiatric care (i.e., medication, invalidation of their experiences, and reversing their process as quickly as possible), while those experiencing mystical experiences should receive gentle guidance and
encouragement to work through the process. If we come from the perspective that both categories of experience arise from a similar growth-oriented process, then it should become apparent that regardless of which category we attempt to label an individual’s experiences, they should all receive support and guidance in attempting to work through their process (Laing, 1967; Mindell, 2008; Mosher & Hendrix, 2004; Perry, 1999). One very important implication of this perspective, and one well supported by the research, is that harm can be inadvertently caused by those offering support when they do not accept the possibility that this may be a natural process. By stigmatizing and invalidating individuals going through such a challenging process, we are most likely hindering the recovery process. Another important aspect of offering support, then, is minimizing interventions that hinder the process, chief among these being involuntary hospitalization and compulsory long-term psychotropic medication use, as discussed above.

A third important change the research suggests we make is acknowledging that the process these individuals go through has the potential to contribute greatly to our society. Many authors have argued that by going through what is often a very painful and difficult process in attempting to integrate different realms of experience, loosen ego rigidity, and step outside the box of consensus reality, these individuals may be the very ones who can take on the long-forgotten role that our species needs in order to rediscover a sense of harmony with each other and with our world (Clarke, 2001; Farber, 1993; House, 2001; Laing, 1967; Mindell, 2008; Perry, 1999). Some of the more famous people who are an example of this are Van Gogh, whom many consider to be one of the most inspirational artists of the past two hundred years, and it is generally considered that his “madness” was closely associated with his genius (Shoham, 2002); Carl Jung, the well-
known transpersonal psychologist who spent several years struggling off and on with psychotic experiences and emerged with profound insights into the human condition (Jung & Shamdasani, 2009); and Black Elk of the Sioux (Neihardt, 2008), who experienced a *shamanic illness* in his youth that served him to lead his people through a very difficult integration with the European descendants in the U.S. at the turn of the 20th century. Some other well known figures who also contributed greatly to their societies and who also struggled with psychotic experiences include Sir Isaac Newton (preeminent founder of calculus and physics); Joan of Arc (Catholic Saint and national heroine of France); Virginia Woolf (often considered one of the greatest novelists of the 20th century); and John Nash (winner of the 1994 Nobel Memorial Prize in Economic Sciences).

It is important to recognize that acknowledging the potential contribution of such individuals is not a romanticization of those struggling with psychotic states. It is clearly evident that such individuals often experience tremendous confusion and inner turmoil for significant portions of their lives. Such acknowledgment merely recognizes that such individuals have likely played valuable roles in human societies since the birth of our species; and when we consider the rigid dogmatism that plagues our societies today, it is difficult to deny that we may be harming not only these individuals but all of society when we deny these individuals the possibility of contributing in their own unique way.
Research Focus

A Convergence in the Research

In the review of the literature that I have presented so far, we can see that a wide array of lines of inquiry have all been converging on one central theme. First, we have seen that the brain disease theory is still not substantiated after more than a century of research attempting to do so. Closely related to this, we have seen that full recovery from long-term psychosis is surprisingly common, that recovery is most common when the psychotic process is supported rather than forcefully checked, and that the treatment approaches arising from the medical model have generally hindered the likelihood of full recovery. We have also seen significant evidence that psychotic and mystical experiences are unlikely to be distinct categories, and that both types of experiences may simply be different manifestations of a common underlying process. Closely related to this, we have seen evidence that this process may actually serve as an attempt to cope, heal from, and/or grow beyond an untenable situation; and that successful resolution of this process may actually catalyze the breakthrough into a higher level of functioning and wellbeing altogether. Finally, we have seen that a number of the theoretical models that are in close alignment with the research suggest that the psychotic process may be closely associated with a profound reorganization of one’s understanding and experience of one’s self and the world, or in simpler terms, one’s personal paradigm. Because I have found that the research converges so strikingly on this theme, I have chosen to focus on the transformation of one’s personal paradigm throughout the psychotic process, the details of which I will discuss shortly. First, I will look at the gap in the literature in this regard that I believe should be filled.
A Significant Gap in the Literature

In spite of the superior congruence of the emerging data with the growth-oriented
model of psychosis as opposed to the medical model, the vast majority of the research on
the topic of recovery from psychosis continues to be grounded in the assumptions of the
medical model. Between 1995 and 2005, it is estimated that only 1 in 200 (0.53%) articles on schizophrenia gave any mention at all to subjective experience (Geekie &
Read, 2009), with the vast majority of research searching for biological correlates. Based
upon my own review of the literature, it appears that even the majority of those studies
that did consider subjective experience assumed the validity of the medical model. The
research that has been conducted on the recovery from psychosis looking through the lens
I am presenting here is very scarce indeed. On one hand, this is very unfortunate, since
this theoretical lens does appear to fit the research much better than that of the medical
model; on the other hand, the fact that there is so much room to explore and study offers
hope that perhaps we can learn how to support those suffering from psychosis much more
effectively that what is generally being offered now.

Of the very few studies I came across that looked closely at the subjective
experience of psychosis and recovery (which, by definition, are generally qualitative
rather than quantitative), and which also did not hold the assumptions of the medical
model (either explicitly or implicitly), the majority of these are biographical and
autobiographical accounts (for example, Bassman, 2007; Clover, 1999; Dorman, 2003;
Greenberg, 1964; Modrow, 2003; Sechehaye, 1951). Virtually every one of these lends
validity to the growth-oriented model of psychosis in that they tell the stories of
individuals who, for various reasons, found themselves in existentially untenable
situations, and as a result of the successful resolution of a psychotic process, found themselves living in a significantly more enjoyable and sustainable way. I believe these personal accounts are extremely helpful in that they have the potential to offer hope and guidance to those who are still in the midst of psychosis; and although the number of such accounts is still very small considering the vast amount of literature promoting the medical model and the myth of “no genuine recovery,” it is very heartening to see that such accounts are becoming more common, and that this particular gap is beginning to be filled.

What I found particularly surprising during my review of the literature was just how few qualitative multiple-case studies there have been that explore the experience of those who have suffered from long-term psychosis and now consider themselves fully recovered. As I mentioned above, one likely reason for this extreme paucity is the intense pervasiveness of the medical model within the scientific discourse which brings with it the assumption that full recovery is simply not possible. It is interesting to note that of the few studies I did find (Farber, 1993; Nixon, Hagen, & Peters, 2009, 2010; Hagen et al., 2010; Thornhill, Clare, & May, 2004) of this nature, they all identified a growth-oriented process taking place within the experience of these participants. I will now briefly summarize the most pertinent findings of these studies.

In Farber’s (1993) study, he paid particular attention to the harm inflicted to his seven participants by the treatment of the mental health care system; their personal transformation was also mentioned but was somewhat tangential. While the implications of his study are numerous, there were two primary findings: First, for all seven of these individuals, as with most of the biographical accounts mentioned above, their psychotic
process was closely associated with a re-creation of their self on a very deep level as they made the shift from an untenable way of being in the world to one that was much more sustainable and satisfying; second, it is very clear that the mental health treatment that they received (were often forced to receive) tremendously hindered this process.

Thornhill et al. (2004) used narrative research with 15 participants who identified themselves as recovered or recovering from one or more psychotic episodes (interestingly, the participants were each allowed to define their own recovery, the specific definitions of which varied). The authors found three contrasting narrative themes that captured the essence of how these participants found meaning in their psychosis: the escape narrative, the essential elements of which are “physically escaping the hospital and unwanted treatments” (p. 188) and/or “escaping from the imposition of a certain kind of belief system and from the identity of a chronic psychiatric patient” (p. 188); the enlightenment narrative, the essential element of which is “the sudden or gradual dawning of understanding, bringing a new perspective... [which often includes] developing important insights that can be shared with others” (p. 189); and finally, the endurance narrative, the essential element of which is “the acceptance of life as a struggle, and although some aspects may be positive, an acknowledgement of the need to contend with ongoing difficulties” (p. 190). The authors also mentioned two particularly significant implications from this research: (1) making meaning of the experience does seem to be important in recovery, and (2) not just one particular meaning but a variety of different meanings seem to be compatible with recovery. The authors concluded this study with the remark, “It may be that the process of making sense of the experience in
ways that are personally meaningful to the individual is one of the keys to recovery” (p. 195).

The three studies conducted by Nixon et al. (2009, 2010) and Hagen et al. (2010) were essentially three different branches of one overarching study involving 23 participants. In one study, Nixon et al. (2009) explored the transformative experiences of the six participants of this group who were considered fully recovered, which the authors defined as being “at a level of higher functioning than pre-psychotic episode functioning, not on psychotropic medication, and [having] reported no psychotic episodes in the past five years” (p. 5), while also “having benefited from psychosis in a spiritual and/or transformative manner” (p. 1). In the second study, Nixon et al. (2010) asked the following question of the remaining group who were considered to be still “in recovery”: “What was the lived experience of people who went through a psychotic episode and are now in recovery?” (p. 3). In the third study, Hagen et al. (2010) focused on the role of antipsychotic medication in all of the participants’ recovery, and their findings demonstrated that “overall, the majority of participants had very negative experiences with psychotropic medications” (p. 1), including significant hindrance in their recovery process.

While the implications of this group’s studies were many, one finding that I find particularly relevant to my own research focus is that most of those participants considered to be still in recovery had reported “an emerging sense of creativity and renewed optimism in day-to-day life” while still often being caught in a struggle comprised of a dualistic sense of intense good and evil forces, and still maintaining strong egocentricity in that they “cling to a sense of specialness related to their
psychosis” (Nixon et al., 2009, p. 12). These were factors the authors believed were perhaps transitional towards full recovery, but which also seemed to hinder “ongoing recovery” (p. 12). Those who fit the criteria as having fully recovered, on the other hand, expressed a key theme of “detachment and mindfulness” (p. 12). They experienced significant serenity, equanimity with altered states of consciousness, a sense of integration between so-called good and evil energies as they moved beyond a dualistic perspective, and a deeper sense of connection with others.

I have found the various biographical accounts and the multiple-case studies mentioned above to be rich and full of potential guidance for those suffering from such experiences and I have found myself feeling disappointed that such studies are so rare, yet also inspired to help fill this enormous gap in the literature. I believe that the study I have conducted here plays a significant role in this regard. I have conducted a qualitative multiple-case study similar to those mentioned above, using a growth-oriented model to explore the experience of those who identify as having recovered from psychosis.

Statement of the Problem

As discussed earlier, the mainstream treatment philosophy for psychosis in the West has typically been to search for ways to suppress anomalous experiences and return the individual to her or his pre-psychotic way of being. However, when looking through the theoretical lens of the growth-oriented model, we see recovery as not necessarily entailing the return of an individual’s experiences to conformity with consensus reality, and we find the possibility of a very different treatment philosophy emerging. Instead of asking, How do we return an individual to his or her pre-psychotic way of being, we may find it more helpful to ask, “How may we support such individuals in moving through the
psychotic process so that she or he may integrate this experience into a new way of being in the world that provides fulfillment, healthy relationships, the ability to meet their needs, and a relative sense of wellbeing?”

My desire with this study, then, is to learn more about how we can offer genuine support to those in moving through this process. The research demonstrates quite soundly that many people experience full recovery from long-term psychosis; it also demonstrates that such recovery often, and perhaps typically, involves a profound reorganization of one’s understanding and experience of oneself and the world (i.e., their personal paradigm). Therefore, I chose to study the personal paradigm shift(s) experienced by those who have successfully navigated through such a process in the hope that this will offer some helpful insight and guidance for those still struggling within psychosis.

Research Question

I have approached this research from a lens through which the psychotic process can be seen as a natural response to extraordinary circumstances. May (1977) suggested that “many forms of psychosis are to be understood as the end result of conflicts and anxiety which are too great for the individual to bear and at the same time are insoluble on any other level” (p. 326). In other words, the psychotic process may not be something that falls outside of the realm of natural human experience, but it is perhaps an exaggeration of more ordinary human responses and experiences brought about by extreme circumstances.

Given that we are multi-layered beings, it is clear that such extreme circumstances can affect us on many different levels. For example, we can be affected physically, psychologically, emotionally, interpersonally, etc. Schneider (2008) posited a useful
model in this regard, suggesting that our experience can be divided into six different levels (or domains) of consciousness, all of which are highly interrelated: physiological, environmental, cognitive, psychosexual, interpersonal, and existential. Each level represents a deeper domain, with the physiological level residing at the surface and the existential level residing at our core. As I inquire into the participants’ journeys through psychosis, it is the effects at their core existential level that I hope to directly address.

Geekie and Read (2009) have recently conducted an extensive grounded theory study of those diagnosed with schizophrenia. They speak directly to this existential domain when they mention their finding that both one’s personal epistemology (the framework with which one acquires knowledge about the world) and one’s personal ontology (how one understands and experiences the nature of being) “were significantly shaken by the experience of psychosis, which often left the person facing quite profound uncertainties about aspects of life and living that most of us, most of the time, simply take for granted” (p. 67). The intention of my research here has been to expand on this discovery and explore how the participants’ personal ontology and epistemology (i.e., their personal paradigm) were shaken up and reformed as they traversed into the depths of psychosis and back out again. Geekie and Read’s statement above implies the assumption that psychosis led to the “shaking up” of one’s personal paradigm, but I think we should be careful with these kinds of assumptions. Perhaps one’s personal paradigm was shaken first, and this is what led to psychosis—perhaps a shaken personal paradigm is one of the extraordinary circumstances that has the potential to initiate a psychotic process; or perhaps these two phenomena are so interconnected that the order of
causation is simply irrelevant. These are exactly the kinds of issues that I have addressed in this study.

So, in summary, in this study, I inquired into the participants’ basic experiences and understanding of the world, of themselves, and of their relationships with the world; and I inquired into how these experiences and understandings may have changed during the various stages of their psychosis, from onset to full recovery. My primary focus was to explore how these experiences and understandings may have related to their experiences of overwhelming anomalous states, and what role they may have played during the various stages of their journey towards recovery. My intent was to learn if such an exploration might provide us with some universal guidelines and possibly a relatively comprehensive model that could be useful in supporting others who are either on the verge of psychosis or are in recovery.

To answer these questions, I posed the following questions (and other related questions) to participants who have descended into long-term psychosis and who now consider themselves to be recovered:

- **Can you describe any experiences that you believe were directly associated with the onset of your psychotic experiences?**
- **Can you describe any experiences that you believe were directly associated with the intensification of your psychotic experiences?**
- **Can you describe any experiences that you believe were directly associated with your recovery?**
- **Can you describe any questions, insights, paradoxes or epiphanies that you believe were directly associated with the onset of your psychotic experiences?**
- **Can you describe any questions, insights, paradoxes or epiphanies that you believe further intensified the psychosis?**
Can you describe any questions, insights, paradoxes or epiphanies that you believe led to recovery?

How has your understanding and experience of yourself developed and changed within the various stages of your psychotic process?

How has your understanding and experience of the world and/or reality developed and changed within the various stages of your psychotic process?

What do you believe were the most helpful resources to you in your recovery?

How would you describe your overall sense of wellbeing now as compared to that just prior to your psychotic episode?

How would you describe your overall ability to meet your needs now as compared to that prior to your psychotic episode?

How would you describe your relationships with others now as compared to those prior to your psychotic episode?

Results of the Pilot Studies

In the Spring of 2010, I conducted two exploratory pilot studies utilizing the same research question posed above. While I did maintain the research question above in these studies, I conducted them with the specific intention of preparing for this study, and so my emphasis was placed more on assessing the viability of the theoretical framework I have been proposing here and on finalizing my methodology, and somewhat less on a thorough exploration of the participants’ personal paradigm shifts.

In the first pilot study, I used qualitative single-case study methodology of a participant who had suffered a significant psychotic episode, although I had not set forth the requirement of long-term psychosis in this first study. In retrospection, it is difficult to say if his experience would have satisfied this definition, though if not, it would have been close. I collected data in the form of an initial live face-to-face interview followed by two follow-up email interviews.
In the second pilot study, I used qualitative multiple-case study methodology with two participants. In this study, I did explicitly require that the participants satisfy my definition of long-term psychosis (as defined above in the terminology section), and they both satisfied it easily, each having intense psychotic experiences off and on for a number of years. I collected data via two questionnaires, a live telephone interview, a follow-up email interview, and a quantitative inventory (the Posttraumatic Growth Inventory [PTGI]; Tedeschi & Calhoun, 1996).

Following are what I believe to be the most significant results of these two studies:

First, the results of these studies clearly support the conclusions drawn by a number of researchers that psychosis may actually be closely associated with the psyche’s attempt to reorganize itself (i.e., to survive, heal, and/or grow) when it finds itself in an untenable situation (Arieti, 1978; House, 2001; Laing, 1967; Mosher, 1999; Perry, 1999; Siebert, 1999). All three participants expressed having experienced a natural process unfolding within their psyches, and they all expressed experiencing a higher level of functioning and wellbeing now than in the time period immediately prior to the onset of their psychotic process.

Second, the results of this study support the already existing evidence that suggests that when people going through such a process are provided with genuine support and are encouraged to allow the process to unfold naturally, they have a much higher likelihood of recovery than those with whom the process is forcefully checked (Farber, 1993; Hagen et al., 2010; Mosher, 1999; Perry, 1999; Seikkula, 2006; Whitaker, 2010). All participants expressed that their recovery was greatly facilitated when they
found validating peer support, and they all expressed that when their process was forcefully checked (such as by their own fear of the process or in their dealings with the psychiatric system, as was especially the case with the two participants in the second study), their recovery was greatly hindered.

Third, Arieti (1978), Mosher (2004), Perry (1999), Mindell (2008), and others who have significant clinical experience working with this population have suggested that important factors in recovery are a willingness to actively engage with the psychotic process and a desire to gain insight into it. All participants in the pilot study clearly made heroic efforts in this regard. While it may appear that these are atypical participants in that they all applied themselves so courageously and diligently, it is possible that as we collect more data, we may discover that these qualities are more typical than not for those who have made such successful recoveries.

Fourth, the experiences of all participants were in clear alignment with the suggestion made by numerous clinicians and researchers that there is not a neat dichotomy between spiritual crises (e.g., spiritual emergency, Kundalini awakening, etc.) and so-called pathological psychosis (Brett, 2002; Claridge, 2001; Clarke, 2001; Laing, 1967; Margree, 2002; Mindell, 2008; Perry, 1999). It is clear that all participants had experiences that overlap both of the traditional categories of spiritual experiences and psychotic experiences, a finding that is in alignment with other studies that have performed such comparison (Chadwick, 1992, 2001; Jackson, 2001; Jackson & Fulford, 2002; Peters, 2001).

Finally, the results of this research are in alignment with previous research that suggests that the process these individuals go through has the potential to contribute
greatly to our society (Clarke, 2001; Farber, 1993; House, 2001; Laing, 1967; Mindell, 2008; Perry, 1999). Some have suggested that by stepping outside the “box” of consensus reality (albeit often unintentionally and haphazardly), these individuals may be in a position to see more clearly the troubles within a society to which the collective tends to be blind. Similarly, it has been suggested that it may be the hidden and/or suppressed troubles of a society itself that often trigger these processes in unusually sensitive people, and that therefore such a process may be an attempt to heal not only the individual’s psyche but also the larger collective psyche (Clarke, 2001; House, 2001; Mindell, 2008; Perry, 1999). All three of these participants had deep insights into the suffering found within our society; and all three of them, as a direct result of their processes, have developed the desire to contribute to their community and society and engage directly with these troubles.

Despite some of the limitations of these studies (e.g., the use of a participant with a relatively short-term psychotic episode in the first study, and a limited number of participants in both studies, which of course includes a lack of cultural diversity) I feel these pilot studies were very successful in meeting their objectives: confirming the viability of my research focus and question, helping to illuminate other research that is most relevant to this research topic, and fine-tuning the nature and the use of the instruments (the questionnaires, the interview questions, and the PTGI; Tedeschi & Calhoun, 1996) for the present study. The results were highly congruent with the growth-oriented model of psychosis, and therefore highlighted the importance of continuing research along this path.
Design and Methodology

Choice of Method

This study is an exploratory qualitative (with the support of one quantitative instrument) multiple-case study involving six participants and utilizing multiple data sources. I have chosen qualitative rather than quantitative methodology because (1) I am giving importance to the theoretical lens through which this research is viewed (an essential hallmark of qualitative research; Creswell, 2007); and (2) the qualitative paradigm is much more appropriate for “understanding the meaning individuals or groups ascribe to a social or human problem” (Creswell, 2009), which is the case in my research here.

I have chosen case-study methodology in particular because, within the qualitative research paradigm, case studies are considered to be among the most useful approaches for “providing an in-depth understanding of a case or cases” (Creswell, 2007, p. 78). The multiple-case studies design, in particular, has been demonstrated to be highly effective in achieving a deep understanding of a specific phenomenon, which in this case would be the transformation of one’s personal paradigm as one moves through the psychotic process. One particular strength of the multiple-case studies design is its ability to uncover consistent patterns of behavior and also, and perhaps more importantly, its ability to uncover new and even unexpected themes and thereby expand upon existing theory or even generate altogether new theory.

Another important aspect of the multiple-case study design is that it follows replication logic, not sampling logic (Yin, 2009). In a standard quantitative study, the group of participants represents a single sample within a single study. In a multiple-case
study, however, each participant is most appropriately viewed as a separate single-case study in their own right; therefore, the multiple-case study I have conducted here is analogous to conducting six replications of a single-case study, which provides the potential of providing significantly more external validity than we are likely to find in a standard quantitative study with a sample of six.

Although it has been argued that qualitative research has the potential for more study effect and researcher bias than quantitative research, several decades of such research have shown that these issues can be effectively addressed using rigorous data collection and analysis techniques. The multiple-case study method, in particular, has been demonstrated to be particularly effective for both exploratory research and theory development (Creswell, 2007), both of which are important aspects of the study I have conducted here.

**Participants**

The six participants in this study were required to satisfy primarily three criteria:

1) They must have experienced long-term psychosis (as defined in the terminology section).

2) They must now consider themselves recovered (as defined in the terminology section). In addition, they must demonstrate that they have been continuously and self-sufficiently meeting their needs without the significant use of psychiatric medications (or the significant use of any other psychoactive substance) for a minimum of three years, and be willing to have either a therapist, a close relative, or a close friend sign a *recovery testimonial* in this regard.

3) They must demonstrate a high level of memory of their experiences within their psychosis and have spent significant time reflecting upon these experiences.
Data Collection

To recruit participants, I set up a website with information and an *initial screening questionnaire*, and I sent out recruitment emails electronically to various advocacy and peer support organizations, and also to some individuals who I thought might satisfy the criteria. I selected the first six individuals who filled out the initial questionnaire (see Appendix A), the recovery testimonial (see Appendix D), and who satisfied the criteria. I then asked these participants to complete the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996; see Appendix C), a standardized instrument (which was generated using factor analysis) designed to quantitatively assess the amount of personal and spiritual growth individuals have attained as a result of a crisis (the participants’ psychotic crises, in this case). Following completion of the PTGI, we scheduled a live telephone interview. I gave the participants a list of guiding questions (the same questions outlined above in the *Research Question* section) at least one week prior to the interview and requested that they spend some time contemplating these questions before the interview. The interviews were all between one hour and one and a half hours long and consisted of my presenting them orally with the guiding questions and other closely related questions intended to ask for further elaboration. Approximately one to two weeks after the live interview, I sent each participant a set of follow-up questions via email. These questions will be individually tailored to ask for further details and/or clarification related to the initial live interview. As I moved through the data analysis procedures, I sent out two more sets of questions via email to continue elaborating on the data already collected and filling in the gaps that emerged during analysis of the data.
Data-Analysis Procedures

Creswell (2007) suggested that all qualitative research essentially follows the same three steps in analyzing data (though the specific details may vary widely): (1) organizing the data in preparation for analysis, (2) condensing the data into themes via the process of coding, and (3) introducing the themes. These steps are not necessarily followed in strict sequence, however—for example, it is common practice to go through steps (1) and (2), and then gather more data and therefore repeat steps (1) and (2) again. This is the sequence that I followed in my own data analysis, the details of which follow.

First, in step (1), the organization and preparation stage, I transcribed the recorded live interviews and then combine these data with the data from the questionnaires. I then pored over these data repeatedly, carefully removing redundant and/or irrelevant material.

Then, in step (2), the coding stage, I first repeatedly reviewed the data, condensing them down to a minimum of 25 of the most relevant themes. I then further narrowed these down via aggregation as appropriate until I arrived at the most salient themes for each of the six pre-figured overarching categories: (1) description of the anomalous experiences; (2) the onset and deepening of psychosis; (3) reintegration and recovery; (4) lasting existential shifts; (5) lasting benefits; and (6) lasting harms. These are the final categories that naturally emerged within the data analysis during the second pilot study (which is the study upon which this current study is most closely modeled); and I found that they effectively captured all themes for all participants of the present study. Notice that these pre-configured categories generally follow a chronological order. This is one type of time series analysis suggested as an appropriate analytical method for
multiple-case studies (Yin, 2009), and I believe that this method has facilitated this research very well.

Then, after completing step (2) and having arrived at a preliminary set of themes, I conducted follow-up email interviews to fill in missing details and/or to confirm or disconfirm the subthemes that have been emerging. This required me to return again to step (1) of the data analysis process (further organization and preparation of the data as I combined the newly collected data with the data collected earlier) and then again to step (2) of the process (reanalyzing this new compilation of data).

The final step in the analysis of the qualitative data consisted of introducing the themes. Upon completing all repetitions of steps (1) and (2), I compiled individual reports for each participant in which I presented all the themes for the six overarching categories. I then asked each participant to verify the final results of this analysis in order to maximize internal validity. I then carried out a cross case analysis and identified all of the converging themes I could identify along with their divergences. After doing this, I conducted one final set of email interviews in order to fill in any missing details that had become apparent during this stage. Finally, I presented the results of the cross case analysis in both a detailed outline and a condensed table.

After completing the analysis of the qualitative data, I brought in the quantitative data (the PTGI inventory), which provided a separate line of inquiry with the intention of strengthening internal validity by demonstrating converging lines of inquiry.

Finally, after gathering all data, I discussed the implications of the data. To facilitate this discussion, I first developed a theoretical model by conducting an exhaustive process of triangulation between the data, other relevant literature, and the
model. This consisted of formulating a preliminary model based on the data, then
comparing this with the existing research, modifying the model, returning again to the
data, again modifying the model, etc., until I arrived at a model that best fit both the data
and the existing research. This model then became the framework with which I discussed
the implications of the data.
Results

After conducting thorough analysis of the data as discussed above, combining all qualitative data (questionnaire data, live oral interview data, and email interview data), I arrived at a set of themes for each prefigured category of experience. In the individual reports presented below, I made the effort to present the results of this analysis in such a way that the most relevant themes for each category of experience are clear and concise while also maximizing the coherence of the narrative of each participant’s journey through the entire psychotic process. After presenting all six cases in this manner, I will present the quantitative data—the results from the Posttraumatic Growth Inventory.

The Case of Sam

Brief biographical sketch. Sam is a 57 year old Caucasian male living in the Northwestern United States. He had his first experience with psychosis at the age of 19. During his twenties, experienced six or seven psychotic episodes, each ranging from two to six months. During this time, he had numerous acute hospitalizations and two relatively long-term hospitalizations at a state hospital, remaining there for three months during the longest stay. He was diagnosed with schizophrenia, manic depression, bipolar disorder, and schizoaffective disorder. He remained on antipsychotics off and on during this period of time (for about ten years), after which he was able to successfully come off of them. Ten years later, in his late thirties, Sam experienced two relatively brief relapses, about two years apart, at which times he took antipsychotic drugs temporarily but then was able to quickly come off of them. He now has been completely free from psychiatric drugs since 1993, and he has not had any relapses since.
Description of the anomalous experiences. Sam’s anomalous experiences were primarily comprised of elaborate unusual belief systems typically involving important roles or missions and occasionally persecution. These belief systems would often overlap with each other, giving Sam a sense of cohabitating parallel worlds.

On the verge of catastrophe. In the initial stages of Sam’s first period of psychosis, he began to have different experiences of impending catastrophe, first with regard to his own life:

Well, uh..I remember I was at a friend’s house and I uh . . . felt for my pulse, and I felt like I didn’t have a pulse for a long period of time. That was kind of distressing. I was still walking around conscious [laughs] . . . . The other ones were, uh, I thought that people had put spells on me, uh, witches . . .

Then they began to expand to include a sense of impending disaster for the world, and along with this came a feeling of needing to act in some way to save it:

I think the most significant aspect of the first one is that, what would happen with me was that all of a sudden I had this . . . some sort of a..uh..I don’t know, vision or something like that..that unless I did certain things, the world was gonna end. And I focused on the song, Bye, Bye, American Pie [laughs].

Involvement with the “initials agencies.” As Sam moved further away from consensus reality, more elaborate belief systems began to emerge. One of the most prevalent types of belief systems involved being involved in various ways with the “initials agencies”: “Either I was being hunted by the..uh..initials agencies, or else I was part of the initials agencies, or else I was doing independent..uh..operations for initials agencies. And when I say initials agencies, I mean things like the FBI and CIA.” One of these missions involved playing an important role in Desert Shield in Iraq:

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1 The direct quotes from the participants come from several sources—both verbal and written. When ellipses are used within these quotes, “…” refers to a significant pause within speech without any omission, “...” refers to an omission of irrelevant words within the sentence, “...” refers to an omission of irrelevant material that spans beyond the present sentence, and ellipsis in forms other than these were directly copied from the participant’s written material.
I was..uh..part of a group that, during the Desert Storm, or..uh..I think it was Desert Shield . . . before Desert Storm started..uh..that Iraqis were..kidnapping people and using them as human shields, and..uh..I had this feeling like I did a mission over there and helped..uh..get those people released. And . . . I used hand signal communications with the..umm..geosynchronous satellites that..at any given time the military geosynchronous satellites have real-time views of the world, and I was using hand signals to bring in airstrikes.

Another mission involved capturing D. B. Cooper (which ended with Sam getting severely beaten by the police and then placed in the state psychiatric hospital for three months):

I was an independent operative that had contracted with the FBI, and . . . just before the..um..statute of limitations ran out, I captured D. B. Cooper [the infamous D. B. Cooper who hijacked a Boeing 737 airplane in 1971, received a ransom of $200,000, and then parachuted from the tail of the plane never to be seen again]. . . . And so I met this guy who had some experience as an aerospace engineer, and..uh..he fit the description of D. B. Cooper, and he also had a lot of receipts on him for spending a lot of money, and so I..uh..was yelling..questioning him in the middle of a Greyhound bus depot in [laughs] downtown, and the..uh..there was a..uh..security guard, and he didn’t like what I was doing, so I kind of jumped all around and evaded him and then I was walking in the downtown area, and that’s how I got caught by the police. He’d given the police a description. I was wearing…uh..Korean paratrooper jump boots..uh..that are very..they have a lot of resilience on the bottom, so I was able to do a lot of evasive stuff by bouncing around [laughs].

**Directing and starring in movies.** Playing major roles within movies was another prevalent theme within Sam’s belief systems. He was actually interested in filmmaking prior to these experiences, something he feels may have contributed to his having these particular types of experiences. Sam describes one such experience in which he was the demolitions expert:

The Earth was going to be used as a [movie] set, and what we had was we had..uh..all the..uh..humans were replaced by..uh..cyborg types, and..uh..what happened was..uh..I..uh..set up a lot of..umm..real time..uh..demolitions to do a lot of..umm..let’s say special effects using the Earth as a..umm..set, a movie set [laughs].
In another such experience, Sam experienced himself as a director of a movie and was “using hand signals to..uh..signal..uh..production staff..uh..so that they would get the right..uh..feeling of a movie.” In another episode, he experienced himself as an actor, and this particular one had severe consequences: “I got in a car crash doing 120..uh..and when I..uh..was involved in driving that fast..uh..I thought there was a camera crew on top of us.”

**Caught in a war.** Sam went through a significant period of time in which he thought he was caught in a war:

*Sam:* There was a time when I was..um..uh..with my girlfriend and..uh..we were going grocery shopping, and..uh..I had the belief that there is war going on on planet Earth all over the world. It’s kind of an odd belief, isn’t it? [laughs]

*Researcher:* Sounds really true.

*Sam:* I, for some reason I thought it had kind of come over to the United States, and so, my..I did a lot of taking cover. So I would take cover, I would..wherever I went, I’d always be in some sort of cover from..uh..live rounds.

**Parallel worlds.** One particularly interesting aspect of Sam’s experience with these various belief systems is that he would quite often experience them as happening concurrently:

*Sam:* I..uh..thought that I was in kind of another universe type thing. I felt like I was jumping between universes..or, as somebody in the modern physics world would say, parallel worlds . . . . Well, it wasn’t always jumping from one to another. They could be multi-layered.

*Researcher:* Right, so they could all be going on at the same time.

*Sam:* Yeah..like the thing with the..uh..you know, D. B. Cooper and all that stuff seemed like it was, you know, I was doing both. I was doing both..the independent work for the FBI, but it also seemed like I was..uh...in a movie that Sam Peckinpah was directing.

Sam describes another experience in which he had a particularly terrifying confusion between his belief system of being caught in a war and what was actually taking place within consensus reality:
Sam: I was..uh..fairly agitated when I was an inpatient in an acute care hospital, and..uh..what happened was..uh..I think I was having a panic attack. I was very anxious, and..I was yelling but I wasn’t violent, and..uh..all of a sudden, I had about ten to twelve people on top of me..uh..in a dog pile, like..and..uh..what happened was my airway was somewhat restricted with all those people on top of me--
Researcher: I bet.
Sam: --and there was a security guard, maybe one or two people up from me, and he had..he had his..uh..walkie talkie, and I..I distinctly remember him saying “call excavation.” So it seemed like I was in a place, like an artillery shell had gone off and I was buried in people and rubble.
Researcher: Wow.
Sam: Kind of a tough place to be.
Researcher: Yeah.
Sam: But eventually they got excavation over there and dug me out.
Researcher: So, it sounds like it was hard to distinguish what was going on like in your own belief system--
Sam: Sure.
Researcher: --versus what other people were actually seeing around you…
Sam: Right.
Researcher: --kind of getting mixed up and confused around the different realms of experience, it sounds like.
Sam: Sure.

The collective unconscious. He recalls one anomalous experience in particular that he now believes corresponds closely with Jung’s concept of the collective unconscious:

During one of my stays at the State Hospital I believed I experienced an anomalous experience related to [what] . . . Jung referred to as the universal unconscious mind . . . . I had the belief that some other patients and I had been on a mission to the moon and spent some time doing extra-vehicular activities. The reason this could be possible is that it has been done by people already—the idea of the archetype. I also had a feeling that we were on an interstellar mission to colonize planets other than earth. I think spiritually I had always thought that all experiences and manifestations of the universe are interconnected. These experiences helped me to solidify these ideas in my mind.

The onset and deepening of psychosis.

Disconnected from his family. Sam describes his childhood as relatively uneventful regarding abuse or traumas. However, he did describe his childhood situation
as one that involved perhaps some emotional neglect and poor connection with his parents: “My father was a doctor and did not spend a lot of time with the family. My mom was a homemaker and spent time with us, as kids. She had mental health and A&D [drug and alcohol] issues. My dad also had A&D [drug and alcohol] issues. I spent a lot of time with my peers.”

\textit{Drafted for Vietnam.} At 18 years old, Sam found himself grappling with the reality that he would almost certainly be drafted into the Vietnam war: “I received a 31 in the 1971 draft at age 18 guaranteeing that I would be inducted into the military at 19. I was an anti-war activist and had a lot of stress from this situation.” This stress eventually came to a peak when he finally received the dreaded draft notice:

I got drafted and I..uh..was kind of going crazy. I was just having a lot of difficulty around that….I was trying to work on a..uh..a valid..uh..conscientious objector claim, and I remember when I was writing up some of that stuff, getting it together, I was writing in spirals [laughs], so that was kind of an indication, I guess, that I wasn’t doing so well.

\textit{Difficulty sleeping.} After being drafted, Sam began to lose a lot of sleep, something he believes was a major factor in the onset of his psychosis: “When people don’t sleep, sometimes they’ll have what’s called psychotic [laughs] experiences. I think anybody, if you deny them sleep, they’ll have these anomalous experiences, especially after 3 to 5 days.”

\textit{Recreational drug use.} Sam also believes that his recreational drug and alcohol use may have played some role in the onset of his psychosis, although he is much less certain about this:

\textit{Sam:} I . . . had experimented with psychedelic drugs at 18 and had been smoking marijuana and drinking since age 16.
Researcher: Would you say that..um..the use of drugs and alcohol was associated with the first [period of psychosis]?
Sam: Well, you know, it’s hard to say..uh..you know, I had taken some LSD and..uh..there are people that believe that..uh..I don’t know about the research, but..you know..they always had this idea of LSD flashbacks--
Researcher: Uh huh.
Sam: --so it could be. I could’ve been experiencing that kind of thing..[but] I can’t say it was directly related, because I hadn’t taken it. I had taken some, maybe..uh..maybe six months before, but not when the experience occurred.
Researcher: Uh huh.
Sam: So, it’s hard to make that correlation, unless you go by the theory that people do have LSD flashbacks.

Abuse by the police. Sam suffered a particularly traumatic beating by the police after his arrest that resulted from his attempt to capture D. B. Cooper at the Greyhound station, and this abuse may have played a role in exacerbating his condition:

They asked me some questions and I didn’t talk, so they gave me that treatment . . . . They had me back in the back of a..uh..car, and both of them beat me up using their..they had billy clubs back then, so they’d use these billy clubs and beat me up in the back of the car, then they’d drag me by the hair into a foyer in the booking facility, and then one or both of them, I can’t tell how many of them ‘cause I was face down in handcuffs on the floor, jumped up and down on my back . . . . [Then] they took me in and had me in a holding cell..uh..I..got a call directly from God to tell me to stop being a bad boy [laughs].

He was subsequently sent to the state hospital for three months.

Antipsychotic drugs hindering recovery. Sam was placed on antipsychotic drugs for approximately ten years, beginning with his first period of psychosis at age 19. While he does believe that they played a supportive role at times (more on this later), he feels that, overall, they were more of a hindrance than a benefit. One major hindrance of these drugs was their impact on his cognitive abilities which resulted in a major interruption in his academic studies: “I had trouble thinking when I was on the medicine. I was on and off of it for about ten years. Then, once I got off of it, I was able to get my thinking faculties back and go back to college and complete my bachelor’s degree.”
Sam believes that another feature of his antipsychotic drug use that may have been particularly detrimental to his recovery was their tendency to bring on psychosis after sudden withdrawal. Sam recalls “discontinuing psychiatric drugs cold turkey” on several occasions, and he believes this may have played a role in the onset of a number of his periods of psychosis after the first one.

Recovery.

Reconnecting with his “spark”. Sam describes his recovery as the recovering of his “spark” that he had prior to the terror of going to Vietnam and the subsequent psychosis:

I was just, you know, I was a growing person, a young adult, had been a teenager and was in the end of my teenage years, and I had explored a lot of different things having to do with direction in my life and that kind of thing. But, you know, back then, there was..uh..kind of this spark in me..uh..that made me the personality of who I was, and what happened was, is that when I started having the experiences early on..uh..I don’t know if I could..partly it was the experiences, quite a bit of it was the medication, they put me on Thorazine. It took a lot of that spark of who I was and kind of dampened it a little bit. So, the person [Sam] was not really there. It was more like a..sort of this..sort of zombie-like [laughs] guy who didn’t really have the spontaneity or sense of humor, that kind of thing, that I had before I had these experiences, and so what happened with me was that, going through the things I’d been through, I’d been able to recover that part of myself, the part that was the spark that was my personality, who I am. So I was able to..to recover that part of myself while..uh..while..uh..kind of currently developing..uh..into an adult, and the main thing that happened with me was I had like a ten..ten to twelve year period of..uh..what..what somebody told me was like an interrupted life . . . . So, I had to go through some of the development things that most people go through at 20, and..uh..20 to..25 or whatever, I had to do those at 32 to 38, you know. So, but..uh..I think the key is that I was able to..uh..sort of..uh..refind..uh..the person I used to be, but..was also developing other parts of myself at the same time once I was able to get off the medicine.

Returning to college. After getting off the antipsychotic drugs, Sam was able to “go back to college and complete [his] bachelor’s degree.” This played an important role in creating some meaning in his life which contributed to his recovery.
**The judicious use of antipsychotics.** For Sam, a major factor in reconnecting with his spark was in making the shift from receiving harmful treatment to receiving helpful treatment. Initially, he was placed on a heavy prescription of antipsychotic drugs, with the instructions that he was to remain on them for life: “As the episodes occurred, I’d be medicated, but I was medicated between the episodes, too, and..uh..you know, it was just..it was just the incorrect choice..the doctors made to continue me on the medication.” As mentioned earlier, he felt that being continually on the medication also put him at risk of experiencing a withdrawal-induced psychosis in the event of suddenly coming off of them. After about ten years of being on the antipsychotics, at the age of 29, his doctor at the Institute of Living helped him come off of them, and this represents a real turning point in his recovery, the point when he began to feel like he was getting his “spark” back and “develop other parts of [himself].”

About ten years after coming off the antipsychotics, Sam had two minor relapses over a period of two years in his late 30’s. However, he managed to find doctors who had an alternative treatment philosophy, and Sam found this much more beneficial:

*Sam:* After I got off of medicine for approximately 10 years, I had some stressful occurrences and was able to..uh..find doctors who would treat me for those particular experiences and then take me off the medicine.
*Researcher:* Right, so you would use maybe just short-term medication?
*Sam:* Short-term medication use seemed to help fairly well.

**Self-hypnosis improving self-esteem.** At one point during the more acute stages of his recovery, Sam turned to a type of self-hypnosis:

I got involved in a lot of things having to do with self-hypnosis, and..uh..reprogramming [my] brain. I reprogrammed my brain, and that helped me quite a bit . . . I used a lot of tapes from a group called *Potentials Unlimited.* It was a group that sold self-hypnosis tapes, cassette tapes. And so I would get these, and you know, they had them on self-esteem, making decisions, you know, all different kinds of areas that you’d look in your life, and they seemed to help
me quite a bit. They also had a subliminal side to it, where you’d get the messages by listening to some music on one side. So I used those. Those were very effective not only in helping me sort of heal, but also progressing me in my life as a self confident...I wasn’t very confident. Unfortunately, when you get to the [mental illness] labels and stuff, it doesn’t help your confidence level too much. Now I’m a lot more confident before I even had the problems.

**Self care.** One essential component of Sam’s recovery was his transition towards paying much more attention to taking care of himself. This included stopping the use of recreational drugs: “I had stopped using drugs and alcohol. You can’t believe what that does for your mental health [laughs].” He also became much more diligent about ensuring he was getting good sleep, coming to believe that this is one of the most important factors in ensuring he doesn’t slide back into more distressing states of mind:

*Researcher:* And what kinds of things have you learned to do when you start to recognize that you might be kind of going back into those experiences, what has really helped you the most?

*Sam:* Sleep.

*Researcher:* Sleep, okay.

*Sam:* Yeah, I have [laughs]. I have..uh..a very strict sleep schedule. I’m not all over the place on sleep. I go to bed between 9 and 10 on workdays, and I go to bed between, you know, 9 and 11 on weekends when I don’t have to work the next day. And then I get up right around the same time, 6:30 to 8 every day. I don’t sleep until 11 or 12 or something like that. So I have a very strict sleep schedule.

…and for those times when he’s feeling too “amped up” to sleep:

... when I’m losing sleep, if I’m amped up, if I think I’m getting amped up, I know I need to do some things to relax, so I have some real good relaxation techniques. Hot baths are probably the best thing I can do. I always like taking a hot bath, and I still do it, I don’t need to have the excuse of, you know, I might be having an anomalous experience to take a hot bath [laughs].my muscles require that.

**Creative outlets.** Another important resource for Sam has been a variety of creative outlets: “Writing has helped..umm..uh, as I mentioned, I am also a musician, so that has helped. Um, I do artwork, that’s helped. So, I have a bunch of different creative
Sam has found that his psychotic experiences and his creative outlets have, in some ways, mutually supported each other. Not only have Sam’s various creative outlets helped him to integrate his experiences, the experiences have enhanced his creativity: “I think these experiences have helped me widen out my creativity . . . . The great thing about having these experiences...uh..you feel like you’re describing..uh..you know, things that actually happened, but they make very good fiction.”

**Supportive relationships.** Sam believes that the presence of people in his life who were willing to stand by his side throughout his process was crucial to his recovery:

> When I was going through these times..uh..I was having some difficulty in relating with people that were close to me, and..but, having gone through them, it helps me appreciate how some of the people that are close to me have kind of stood by me and..uh..accepted me both when I was having the problems and now that I’m healed from the problems, so I think that’s the key.

**Lasting personal paradigm shifts.**

**A stronger sense of connection with the world and others.** Sam experienced a broadened and heightened range of feelings after emerging from psychosis, but finds that these have generally faded over time: “I find that as time separates me from the experience, these heightened feelings have been fading.” He finds, however, that he has maintained a stronger sense of connection with others and the world in general: “I still appreciate my connections with the world and the people.”

**A stronger sense of interconnectedness and possibility.** Closely related to Sam’s increased sense of connection with the world and with others is an increased sense of a more general interconnectedness: “I think spiritually I had always thought that all experiences and manifestations of the universe are interconnected. These experiences helped me to solidify these ideas in my mind.” Sam continues to take inspiration from the
insights he gained from these experiences: “There are infinite possibilities and I am eager to learn all I can about all possibilities.”

**Parallel worlds.** Although Sam has not lost his grasp of consensus reality for many years now, he has come to believe that there is some validity in his perception of parallel worlds:

> You know, I have never ruled out the parallel worlds theory . . . . So, you know, I could say, well, at one level, these things actually did happen, and then on the other level, the one within the time-space continuum which you and I share, these things are things that were...uh..happened due to...uh..the way my neurons were firing.

**Seeing the limitations of consensus reality.** Closely related to Sam’s understanding of the validity of parallel worlds is his understanding of the limitations of consensus reality:

> Sam: Well, you know the odd thing about consensus reality is that each person’s view of reality is so narrow that they have no idea of what’s going on in the universe. I don’t think any of us really knows what’s going in the universe. Uh, I worked with a fella yesterday, he’s never been on a plane, and he’s never been on a train, so I...you know...there are people who just don’t have a view, and we don’t, you know, our view of things that go on in the world is filtered. We don’t know what’s going on in the world. We think we do, we see things that help us with...reports of this and reports of that, but our, you know, our view of the universe is very limited.

**Researcher:** So, it sounds like you’ve gained a real appreciation regarding just how limited our view is of the world, and that the world is actually so much broader than any one of us is ever able to fully perceive, is that right?

**Sam:** Correct.

**The ability to hold paradox.** Sam finds that he is now able to better hold paradox within his understanding of the world.

**Researcher:** It sounds like the way I’m hearing you talk about [parallel universes], and correct me if I’m wrong, it sounds like you’ve been able to embrace the idea of paradox a little bit more, the idea that it can be this and that.

**Sam:** Right. I don’t think a lot of people understand that concept well, I don’t know if a lot of people understand the idea that the experiences were real for me. I was experiencing all the stuff that I described, but I can look back on it and say,
you know, there was..uh..a little leakage..uh..between..uh..the vibrational process of this universe and the vibrational processes of other universes, so..uh..I can say, you know, that could’ve..that happened, and I can also say, I can look back and kind of laugh and..and be part of this universe and say, boy, that’s pretty wild crazy stuff there [Sammy] [laughs]…you know, that kind of thing. So I can look at it in both ways.

Some understanding of the cause of his anomalous experiences. When reflecting upon his own psychosis, Sam believes that there were two different ways that he may have been experiencing a confusion of different realms or dimensions, which are not necessarily mutually exclusive: “I think my brain reacted to lack of adequate sleep and my dream life intruded into my waking consciousness. Another possibility is that my consciousness and corporeal self were jumping between dimensions of the multiverse.”

A strong desire to contribute to the healing of others. As Sam went through his own process of psychosis and recovery, his desire to contribute to the healing of others has also flourished along with a sense that his own experiences can be of service in this regard:

Sam: What I hope is that others can benefit from maybe some of the things that happened with me. Uh, that is my goal in..in the work that I do, I try to help people using some of my experiences.
Researcher: Mmm, so you’re really wanting to contribute to others based upon your own wisdom that you’ve gained from going through these experiences yourself?
Sam: Sure. Yeah. It’s my dharma.

Sam has been working towards this goal by trying to improve the mental health care system. He works now in a state hospital supporting patients in reintegrating back into the community and now, having been on both sides of the locked door, he has significant insight regarding the serious problems of the current mental health care system, and he strives to make a difference:
I would like to do what I can, not only to help people, but change the way we do our business in the mental health world. It’s…it’s not quite recovery focused yet. We still have a ton of work to do . . . . It’s hard being part of the culture of change and...and working inside. It can be frustrating, but we’re gonna do it. We’re not gonna stop until we succeed . . . . It’s gonna happen. It may take a generation or two, who knows. I’m hopeful I can live to see it, but I don’t know if I will. But, you know, some of us are the generals of this movement, you know, and we just have to keep...keep chipping away, and winning a battle here and there ‘til we achieve our victory.

**Understanding the harm and benefit of antipsychotics.** One of the changes Sam would like to see in the mental health field is in regards to the use of psychiatric drugs. Again, having experienced both sides of this issue—as a consumer and as a mental health worker—he has developed significant insight into this issue. As already mentioned, Sam felt that antipsychotics helped him somewhat when used judiciously just during the times of severe disconnection from consensus reality, but that the long-term use of them was primarily harmful: “My experience was that use of antipsychotics is OK for acute symptoms, but as long-term prophylactics they have debilitating effects.” Even with the benefits he mentions here, however, he still feels that, overall, his use of antipsychotics was more of a hindrance than a benefit.

**Lasting benefits.**

**Increased wellbeing and resilience.** Sam expressed experiencing a greatly enhanced sense of wellbeing and resilience as a result of his process. Specifically, he has found that he is more often in a state of contentment, and when falling out of this state, he finds he can return to it more quickly:

*Sam: I think that [these experiences have] given me...uh...probably an appreciation of where I am, so that I’m almost in a state of...uh...I don’t know...constant...uh...bliss? I don’t know how you’d describe it, but, you know, it’s very rare that, you know, things in the world bug me [laughs] much. I think, you know, things do bug me, I don’t like people getting beat up, and you know, I hate injustice, but at least for my own personal wellbeing and how I am...uh...I have a*
pretty good attitude about things in the world, and how...uh...how I’m able to...uh...make sure that I’m doing all right. I still have fights with my girlfriend [laughs], but...uh...at least I can come back from it and just, you know, process it and then...uh...make up and all that.

Researcher: So, would you say that, because of the sort of intensity of these experiences that you went through and you survived, that now you’re much more able to tolerate a wider range of experiences in your life and yourself?

Sam: Pretty much, yeah. That describes it fairly well. It’s like if you’ve been in solitary confinement for...you know...I had to go, I was in a few times for different amounts of time...uh...days on end. If you’ve been through that in your life and you live, you have your own house, you have your own car, you make a fairly decent living and that kind of thing. If you’ve gone from just being somebody who’s drooling and doing the Thorazine shuffle to where I am now...uh...you know, I’m a pretty lucky guy.

**Increased self awareness.** During Sam’s recovery, he developed a stronger self awareness that played an important role in minimizing the harm from the two relapses that happened in his late 30’s, and have perhaps prevented other relapses since:

[By the time of the two later relapses,] I had insight into what might trigger those types of things or what would be exterior signs for myself that I could check out that I might be going into those problems. So I was able to kind of have an idea...that if I was gonna have anomalous experiences, I had an idea of, you know, what would I be doing, what kind of behaviors I would be involved with, where I’d have those, and then I’d be able to maybe check myself and get some help. And I did that both of those times.

**A sense of meaning and purpose.** Sam feels strongly that his experiences played an important role in his development of meaning and purpose:

I wouldn’t trade my life for anybody. I’m glad I’m who I am, glad I went through the experiences I went through, and they...uh...helped build the character of who I am now. I have a meaning and a purpose in my life...uh...and I wouldn’t, like I said, I wouldn’t trade it with anybody.

**An increased capacity to see the humanity in others.** Sam’s experiences have helped him to see the humanity in others, even those in whom many of us would find it very difficult to do so. He explains that one important aspect of this capacity is the ability to see someone’s harmful behavior as an ignorant response to having been wounded:
I work with people who have murdered people, I work with people..all kinds of people that I work with, and..uh, you know, one of the things that I know is that if somebody goes through a process like that and they’ve done something..uh, very terrible in their life..uh..that they need as much of healing of their soul as they can get..uh..and so..uh..my goal is to help people heal as much as possible, at..uh..not only the level of becoming part of shared consensus reality but being able to make sure that their souls are being sewn back together again.

*An increased ability to be supportive of others.* Closely related to Sam’s increased desire to contribute to others’ healing is an increased ability to do so:

>[My experiences help] me connect with others who are having similar experiences . . . . When I work with people, I have a certain way to work with people..I have a way to work with people that have had these things that is, you know, I’ve been there type thing, and just connect on a human level rather than I gotta try to fix you type level.

*Lasting harms: Some unresolved grief and trauma.* Sam expressed numerous lasting benefits from having gone through his recovery journey, but he feels there are some lasting harms as well: “I was able to do a lot of therapeutic work to resolve the trauma and grief issues that were associated with my process [but] I still have to face the door in restaurants.”

**The Case of Trent**

**Brief biographical sketch.** Trent is a 52 year old Caucasian male living in the Northeastern United states. At the age of 24, he experienced his first period of psychosis, resulting in his being hospitalized for about six months followed by another six months in outpatient treatment at two different day hospitals. Over the next six years, until about the age of 30, he experienced about seven more significant psychotic episodes, with the duration of each lasting between one day and about a month, although he was never again hospitalized. During this period, he was diagnosed with *catatonic schizophrenia* and *manic depression*, and at the age of 40, he was diagnosed with *attention deficit disorder*. 
Trent used antipsychotics fairly regularly for the two years following his first psychotic episode with at least one subsequent psychotic episode being closely linked to a sudden withdrawal from them. He managed to taper off of them successfully after two years, but then took them again for several months at the age of 40 because he “had trouble sleeping.” Trent has not had any significant psychotic experiences for about 22 years, but for the purpose of this study, since he took antipsychotics for several months about 12 years ago, he would be considered as having been fully recovered for 12 years.

**Description of the anomalous experiences.** Trent experienced a variety of anomalous experiences during his psychosis. Among these were nonconsensus auditory and visual experiences as well as nonconsensus beliefs. The core theme that ran through most of his experiences was a sense of struggling with profound good and evil forces, including direct interactions with God and the Devil, and intense experiences of creativity and destructiveness.

**Auditory and visual hallucinations.** During his periods of psychosis, Trent had a number of nonconsensus auditory and visual experiences, though his recollection is that these were not particularly stressful:

I definitely heard things and saw things that definitely were not there . . . . It was more, uh, voice hallucinations. You know, just, some sentences of . . . . I think mostly, um, you know, I think I heard it in my own voice, you know, I didn’t hear, you know, a stranger’s voice or, you know, a woman’s voice or anything like that . . . . It was kind of like, uh, neutral or odd things. It wasn’t particularly, you know, scary or evil or, anything like that.

**Messages from God.** One of Trent’s more frequent anomalous experiences involved the belief that God was sending him messages in the form of actual events taking place within consensus reality: “I really thought like . . . . God was trying to . . . . give me messages, try to, you know, guide me . . . . a train horn or a flashing light,
you know, or a reflection, you know, little reminders . . . would interpret it as a sign from God.” These would occasionally be associated with “episodes of extreme intensity” in which he felt he could read deeply “into the meaning of things.” Though he had other experiences that included a sense of grandiosity, these experiences were generally very personal: “[They were] just for my own . . . guidance . . . for my own wellbeing.”

**Persecuted by the Devil.** At times, Trent found himself struggling with great fears “of the Devil itself.” He gives an example of one such time:

I remember on one occasion . . . I had the thought that the Devil was gonna come and . . . and take me away. Yeah, yeah, I was gonna die and go to Hell or something like that . . . I was living in my parents’ house and we had two cats, and . . . you know, the cats really sensed that . . . there was something wrong. These cats really didn’t mingle together, they weren’t that type, but they both jumped up on my bed, you know, and kept me company, you know, they just added support, you know how they do it, but they just felt that was their place to . . . to stay on vigil and be by me, and that’s what I needed at the time. But, in my own psychotic poor mind, I thought, you know, the Devil might be in these cats, and I was a little fearful of that. So that’s a shame, ‘cause they were there to help, and here I was thinking that . . . you know, fearing them, it was silly.

**The ability to eliminate all suffering from the world.** Trent remembers some experiences in which he believed that by his own actions, he could alleviate all suffering from the world:

I can clearly remember some psychosis episodes that included believing that overnight and in the morning the entire world would be changed. Free from all its miseries because of something I participated in. And from that day on the world would be free from its sufferings.

**A deep immersion in evil.** Closely related to his fear of the Devil was the occasional experience of feeling inundated with “evil” thoughts and feelings. He describes the worst of these experiences here:

_Trent:_ One of the worst nights of my life was, you know, I had thoughts, you know, so . . . so negative I was dry-heaving blood . . . . You know, just some evil, horrible, negative, you know, satanic thoughts just filled my head . . .
Researcher: Did those thoughts seem like they were your own, or did they seem like they were coming from a source outside of you, or..?
Trent: Um..it..it’s kind of..kind of both, you know. It was something, you know, so deep in me, you know.

Researcher: Was there a sense that you were evil kind of at that time?
Trent: Um..yeah, I was pretty much..uh..um..part of it, I was enveloped in it, sure. I was immersed, I was definitely immersed [laughs].

**Profound creativity.** In contrast to Trent’s experiences of “evil” were experiences of profound creativity:

I really applauded myself later when I got over it, you know . . . about how incredibly creative my mind was, and intelligent, because these were some very intelligent insights, wise, wise, you know, connections. I have no..I couldn’t name one right now, but I remember that was very much the case. I really..really tapped into something very intelligent in my mind.

**Extremes of omnipotence and powerlessness.** As Trent fluctuated through experiences of creativity and evil, feeling guided by God and persecuted by the Devil, he also experienced fluctuations between times when he “godlike” himself and other times when he felt very powerless and hopeless.

**The onset and deepening of psychosis.**

**A dysfunctional family.** Trent refers to the onset of his psychosis as his “mental collapse.” He believes that the single largest factor leading up to this collapse was being a member of a dysfunctional family: “I imploded into a void where a family was supposed to be.” Trent believes that the major contributing factors leading him into this “collapse” was longstanding intergenerational trauma that eventually led to the deep emotional wounding of his parents (he describes his father as having been severely depressed and “sometimes outright emotionally abusive,” and his mother as having been diagnosed with
paranoid schizophrenia). He believes this wounding was then passed down to him in the form of extreme emotional neglect:

My parents were very dysfunctional people that never, you know, got past..that totally avoided their childhood hurts, that really stunted them, you know, personally, you know, and socially and every other way possible, and uh, you know, and they might not be very much to blame because they had very poor role models themselves, you know . . . . It just kept building up generation after generation until it came to me, and I pretty much imploded on it . . . . I had to break the cycle. One therapist in family therapy said, you know, maybe he had a nervous breakdown just so he could save the family, and, you know, there might have been some truth to that. Unfortunately, the family did not see it as an opportunity to save themselves. You know, I’m still dealing with people that..that..uh..are pretty injured.

Trent recalls that he did sense the impending “collapse” before it happened, but he still was unable to avoid it: “I did do a type of distancing myself from them before I collapsed but it only worked so well. My mind and spirit could not tolerate all the baggage and twisted problems that I inherited through contact within the family and chose to collapse.”

**Isolation.** An important factor that Trent feels contributed to his psychosis, one that was directly related to his family situation, was his experience of extreme isolation prior to the onset:

*Researcher:* So would you describe yourself as being..feeling fairly isolated in your years before that, just in general, from your family, or just in general?

**Marijuana and tobacco.** Trent believes that “the use of tobacco and marijuana also played a role in the collapse,” albeit much more minor than the difficulties with his family situation.
Harm from the mental health care system. Trent was “almost immediately hospitalized on the onset” of his psychosis and he remained there for about six months afterwards. Overall, he is very unhappy about the treatment he received there:

In the mental hospital . . . , I was extremely anxious, and I didn’t, you know, I didn’t feel I was getting . . . .any type of . . . compassionate treatment there, more of abuse than treatment . . . . They really, you know, conveyed the attitude, you know, I could go drop dead for all they cared. That . . . that’s the attitude I received.

He recalls being stuck with a therapist whom he feels was a “a real..you know, cold..abusive idiot.” He also felt that they put too much emphasis on medication as the primary form of treatment: “There is no medication that can override a hospital staff including MDs that work in an environment that is open to laughing in a patient's face at anytime.” He also believes he was kept in the hospital longer than necessary to maximize insurance payments, saying “they milked the stay for 6 months.”

During the six months that Trent spent in the hospital, he developed overwhelming suicidal feelings and impulses:

Before..um..my discharge, I was allowed to go home on weekends, and . . . I’d attempt suicide on a weekly basis [laughs] . . . . And, you know, before . . . they let me go, you know, home on weekends, no one ever asked if I was suicidal. I would have said yes if they asked. They never asked. And I did have weekly attempts . . . . I drank some film cleaner, it said fatal..harmful or fatal if swallowed. Uh..I had a plastic bag over my head, you know, rubber bands at night..uh . . . and I tried cutting my wrist, but I wasn’t..yeah, I found that very difficult.

Trent says the lack of care “was very much a contributing factor on me, you know, leaving the hospital six months later suicidal. I didn’t enter the hospital suicidal, I left the hospital suicidal, you know, it was such an unhealthy environment.” A closely related factor in his suicidality, he says, was his lack of ever being given a message of hope: “I was very hopeless. I didn’t think I’d ever recover and ever be decent..uh. It really, really,
really would have helped if they told me...if they gave it the label of a nervous breakdown because I’ve heard of that before, I knew people recovered...from it.”

**The sudden withdrawal of antipsychotics.** Trent may have experienced both harm and benefit from his use of antipsychotics. He believes that the main harm that he suffered from the use of antipsychotics and other psychiatric drugs was related to the often haphazard way in which it was used. One particularly harmful event in this regard occurred when he was abruptly taken off of thorazine while in the inpatient unit of the psychiatric hospital. After withdrawal, he describes behaving in a way that made it very clear that he was suffering from withdrawal symptoms, but the staff refused to put him back on thorazine and instead tried a number of other antipsychotics:

I went in on thorazine, and I started pacing when they took me off thorazine . . . . I began pacing, you know, and I couldn’t stop. I was pacing like 23 hours a day for months . . . . Then they tried a whole bunch of other stuff, you know, which made me worse . . . . For some reason they really didn’t put me back on thorazine for another three months or so, and that’s when I stopped pacing.

Sometime after leaving the hospital, Trent experienced a second abrupt withdrawal from thorazine, which likely played a significant role in slipping into another psychotic episode: “I was on, you know, a large amount of thorazine at the time, and I think...uh...I missed some dosages and that’s what led to a psychotic episode, one of them.”

**Recovery.**

**Medicine might have helped.** While not entirely sure of the benefit of the psychiatric medications he received over the course of his recovery, and of course relatively clear about the harms, as mentioned above, he feels that two of them in particular—thorazine (a typical antipsychotic) and tofranil (an antidepressant)—“might have helped.” He found that while most antipsychotics he tried “made [him] worse,”
thorazine in particular did seem to make him feel somewhat more stable, and he was fortunate in that he experienced very few side effects from it: “Thorazine never made me tired. I heard that’s a side effect, you know, hard to stay awake. I never felt tired on thorazine.” In spite of his negative experiences with psychiatric drugs, he said he felt that “overall it was more of a benefit.”

**Supportive treatment at the day hospitals.** Whereas Trent’s experience with the inpatient ward of the psychiatric hospital could hardly have been worse, he did find that the two day hospitals that he attended after being released from the inpatient unit were helpful: “The day hospitals were a much healthier place than the mental hospital. That’s where I started to sort things out in individual and group therapy.” He feels the second day hospital was particularly helpful:

[The second day hospital] was a little more goal oriented [than the first] and..uh..you know, for people that were a little less..you know, in the hopeless category, and..uh..you know, I sorted things out there, I had more group therapy and..and uh, I was there for..for a couple of months, and then I went out and..uh..into the work force.

**Speaking his mind.** As mentioned above, Trent did find the therapy he received in the day hospitals somewhat helpful and helped him “to sort things out.” In particular, he found that the therapy helped him connect with himself and find his voice, something that he has come to recognize later was particularly helpful in his recovery:

And at the time, you know . . . I didn’t even recognize I was doing that. I was just getting things off my chest. I was just speaking my mind. I didn’t have a whole lot of..uh..you know, self reflection on the process at the time. You know, I was just doing it, I was just living it . . . . I’d try to get to new levels of honesty and openness . . . . The opportunity to speak my mind [was one of the most helpful resources in my recovery].

In spite of these great benefits when the therapy went well, Trent has found his overall experience with therapy and therapists to be “very disappointing”: “You know, I
don’t think I had one therapist, you know, try to, you know, look into what level of dysfunction my parents had for some reason..and..uh, you know, it really would have saved, you know, a lot of time.”

**Giving up marijuana and cigarettes.** Trent managed to give up his use of marijuana and cigarettes “for good within a couple of years of the onset,” and he feels that taking this step was important in his recovery.

**Creative outlets.** Trent has managed to take the creativity he tapped into during his psychosis and turn it towards creative forms of expression, especially writing, poetry, and photography. He feels this was an important resource in his recovery: “It adds to..uh..stability, and a foundation, self confidence, self worth, [self connection], . . . and acceptance, you know, when you get compliments from other people..yeah, recognition. It was definitely helpful.”

**Lasting personal paradigm shifts.**

**Seeing his psychosis as a natural process.** Trent has come to see his journey through psychosis and recovery as a natural process:

In addition to the word recovery I think it should be said it was very much an awakening and new direction from an ill path from a very young age . . . . I believe the collapse was a natural process and the recovery over the course of time was also a natural process for the mind and spirit.

**A new perspective of good and evil.** Trent experienced tremendous polarization of good and evil forces while in the midst of psychosis and even, to some extent, prior to them:

Some of my psychotic experiences indulged in extremely deep and basic and universal issues such as good and evil. So I went directly to the top and directly to the bottom. In a sense I met with God and the Devil. I was quite immersed and survived the ordeal.
After coming through his experiences, Trent has come to develop a very different, less polarized view of the world:

The psychotic process and all that came with it was like going through a washing machine and when I came out I can easily see things as they really were and are and could be. The ordeal helped me confirm that almost everything is really a situation of the heart or the obstruction of the true heart. . . . I think in a way everybody, you know, shares a common heart, and that’s why it’s pretty easy to hear when someone speaks from the heart . . . you can recognize it right away because we kind of share the same heart.

So, Trent has come to see “good” in a sense as that which arises when one is connected with the true heart, and “evil” as that which arises when the true heart is obstructed.

Therefore, he now sees that everyone has the capacity to connect with the true heart:

Um..and uh..so, you know, anyone could be like a Buddha, even Buddha said anyone could be a Buddha. You know, all the answers are really there, you just have to look within, and you can pull out the answers of that heart. And you can see, you know, with a little patience and compassion, you can spot other people’s problems, you know, if you contemplate on them and meditate on them, you can see, you know, where other people’s problems are and why they do the things they do.

He strives in his own life now to have “an open heart to feel another person’s joy and pain.”

A greatly expanded experience of himself and the world. Trent’s view of the world has changed radically since prior to the onset of his psychosis: “Prior to, you know, to the whole breakdown and episodes..um..my vision was extremely limited, you know, I couldn’t…describe or…identify or enjoy, you know, like myself on many levels, you know, or the world..um..and after, it’s pretty, you know, it’s huge, it’s fulfilling, it’s limitless, you know.”

A desire to contribute to others. As Trent has come through his recovery, he has come to value the importance of contributing to the world: “What matters is picking a
battle to save lives and better the world.” He describes here some of the ways he likes to contribute:

[I like to] stand by family and friends, you know, to be helpful..um..you know, I could come up with ideas to, you know, save the planet, save the world, the community. I was a volunteer big brother for seven years to the same kid . . . . It’s like night and day..um..You know, it’s a whole world of difference before and after, and still growing.

An increased appreciation for humor. During his recovery, Trent has come to appreciate the therapeutic benefits of humor and has made sure that it is a regular part of his life:

[Humor] is very important, therapeutic, pleasurable and gratifying for me. I believe it’s an important ingredient in life to indulge in. My own humor and finding [the humor in] others. I even did a little stand-up at open mic nights. I love to get a smile or laugh from people.

The appreciation of creativity. Trent has developed a very high appreciation for creativity in many different forms. He defines art as “anything that moves the spirit.” In a list of his most important values in his life now, he included: “What matters is time taken to express creatively,” and “What matters is taking in other people’s creativity.”

Seeing the beauty of the world. Trent has come to really appreciate the beauty of the natural world: “[What] really matters is our natural world the way nature designed it with all its beauty and creatures. Many are very disconnected from that. Taking time to smell the roses should include taking time to grow roses and get your hands dirty.”

Lasting benefits.

Greater courage in facing challenges. Trent has found that, as a result of coming through his psychotic process, he has developed the self-connection and courage necessary to confront most experiences:
Trent: The whole intense process likely gave me a more deep and intimate understanding of myself than if it never occurred. It helped lead to the loss of any fear or barrier of confronting any issue. I think some people—a lot of people, you know, avoid issues in their life. You know, that’s not me, I’m...um...I can immerse myself with anything...anything in the past. It might not be easy or comfortable for a little while, but I do it and I come out okay.

Researcher: So, it sounds like you’ve gained sort of an increased tolerance, or a capacity to handle more extreme experiences—

Trent: Right.

**Increased resilience.** Closely related to his increased courage in facing challenges is an increased resilience:

*Researcher:* [You’re better] able to bounce back to a more calm place, or a more grounded place, is that--?
*Trent:* Yes. Yes.
*Researcher:* And more trust in yourself, that you can deal with that, deal with more extreme experiences?
*Trent:* Right.

**Increased sense of wellbeing.** Trent feels his sense of wellbeing has improved dramatically since prior to his psychosis: “My sense of well-being at the moment is extremely high even with chronic physical illnesses. Prior to my psychotic episodes I felt extremely ill on a deep and important level. It's like night and day, no comparison.”

Closely related to his sense of wellbeing is an improved sense of confidence and self esteem:

*Researcher:* So, and that’s something that’s kind of changed for you, it sounds like that’s changed for you, huh, is just a general feeling of more self confidence and not needing to prove yourself, or at least less of that than before, or..?
*Trent:* Yeah. Yeah, and it’s...it’s like night and day.

**Improved awareness of his needs and ability to meet them.** Trent expresses having a greatly improved relationship with his needs: “Prior to my psychotic episodes I wasn’t even able to be aware of my needs let alone the ability to meet them. Now I can write the book on needs and how to meet them.”
**More enjoyable relationships.** Trent feels that he has much more rewarding relationships now than he had prior to his psychosis: “My relationships with others now are much more intimate and insightful and compassionate and enjoyable [than] prior to my psychotic episodes.” One factor he ascribes to this change is the increased importance he now gives to connecting with both himself and others, “to be a giving, compassionate, true-to-myself individual.”

**Lasting harms: Social stigma.** The one lasting harm that Trent feels has resulted from his psychosis is the social stigma that has resulted from it, especially considering that authenticity has become a strong value of his:

_Trent:_ Our culture still has a stigma, you know, a strong bias against, you know, mental illness, you know, so much so that they just want to avoid the subject and just leave it to the experts, but, you know, our experts are pretty shabby._

_Researcher:_ So, it sounds like that’s...sort of the stigma attached to having been labeled with a mental illness, that’s kind of still with you in some ways, and that’s still kind of painful, having that label, or...?

_Trent:_ Yeah, yeah, yeah. It’s something I can’t be very open about...It’s very foreign to a lot of people, and so they don’t understand, so it’s not something I shouldn’t just..uh..you know, spew out casually in conversation [laughs].

_Researcher:_ Right. Right [laughs]. And it sounds like ‘cause you really value authenticity--

_Trent:_ Right.

_Researcher:_ --it sounds like it’s kind of hard for you, you have to sort of hide in some ways--

_Trent:_ Right. It’s a shame. It’s a shame.

**The Case of Theresa**

**Brief biographical sketch.** Theresa is a 45 year old Caucasian female. She was born and raised in New Zealand, where she continues to reside. She has been married to the same partner for over twenty years and has two children who are now teenagers. Between the ages of 21 and 23, she suffered two discrete periods of psychosis, with a break of about two years between them, and was diagnosed with schizophrenia and
manic depression. During her first period of psychosis, she was hospitalized for about six weeks and placed on a heavy dose of antipsychotics. She continued to take antipsychotics for about four to six months after leaving the hospital, at which point she stopped taking them completely. She has not returned to the regular use of any psychiatric drugs since, even during her second period of psychosis. She has not had any significant psychotic experiences since recovering from her second period of psychosis, though she has had a few relatively minor incidents of nonconsensus experiences and/or beliefs. According to the definitions used in this study, Theresa believes she has been fully recovered for about ten years. She now works within the mental health field as a consumer advisor, where she offers “peer type” support to those diagnosed with psychotic disorders and other mental disorders.

**Description of the anomalous experiences.** Theresa experienced a wide variety of anomalous experiences, including visions and visual hallucinations, heroic and messianic feelings and strivings, and nonconsensus belief systems. Core themes included experiences of Heaven and Hell, profound interconnectedness, being watched over by malevolent and benevolent beings, and giving birth. She had two relatively discrete periods of psychosis; however, she sees these now as one process that had been interrupted, most likely by hospitalization and the use of psychiatric drugs.

**Finding Heaven.** In the earliest stages of Theresa’s psychosis, she experienced alternating feelings of being in Heaven and in Hell. Initially, when she had moved to Israel to live in a kibbutz community, she had feelings of Heaven that were not radically anomalous. Much of these heavenly feelings were a direct result of finding a satisfying
community after a difficult childhood. However, over time, she “decided it was actually Heaven.”

**Heroic Striving.** As Theresa began to move further away from consensus reality while at the kibbutz, another powerful feeling began to emerge, a feeling “that there was a kind of an ultimate survival somehow”:

I was . . . doing things like climbing a high hill behind the kibbutz and working very hard in the kitchens with no breaks, etc……this seemed to be mainly about how hard I could strive……if I could strive hard enough I could save others from hardships and protect them from having to suffer.

During her hospitalization that took place during the final days of her first period of psychosis, the quality of the heroic striving changed somewhat, becoming more personal:

I had some stuff when I was in the hospital about..about walking through fire and..and having to survive from the ultimate kind of, I don't know, you know, terrible..whatever the most ultimate thing you would have to survive from, I would have to survive from, you know..um..but I think that was more what was happening at the time, you know, [being in the hospital] was a traumatic experience, you know, and I did need to survive [laughs].

During Theresa’s second period of psychosis, this heroic striving emerged again:

The second time was similar in being about physically striving; I had a push bike which I rode all weathers – including long distances thru driving rain etc; walked and then swam out into the sea, walked long distances – aiming to find things to climb (I scaled a really high fence with razor wire on top once and got over it, but was caught by a security guard. I managed to convince him I was lost or something and he drove me home!!). The point of the climbing seemed to be to get to the highest point as then I would be able to see all that was below and take all the suffering I could see away from others.

**Walking through the fires of Hell.** During her first episode, as the feeling of being in Heaven began to fade and the heroic striving strengthened, Theresa found herself becoming more and more immersed in the experience of being in Hell. Some of her experiences in the early stages of this included visual hallucinations on the television: “[I saw] a lot of fiery landscape scenes, kind of classic hell looking stuff, people
transforming into demons, colors changing from normal to red and black. Normal scenes transforming into hellish looking ones. People mutating into horrible looking demonic type creatures.” As these experiences strengthened, she began to have similar experiences out in the world, “not demons or devils or anything like that, but just..just..um..well a lot of fire actually [laughs].” These visual experiences combined with her urges of heroic striving, creating situations in which she “would have to walk through a hell type thing, you know, like fire.”

**Profound interconnectedness.** Another common theme found within Theresa’s anomalous experiences was that of profound interconnectedness, a core experience that was closely related to a number of different anomalous experiences. One such experience was a feeling of universal expansion: “[I] felt like I was expanding or believed I was expanding..um..and there was no limits between me and the universe, and that included being able to kind of move myself anywhere in the universe that I wanted to be, and…being able to communicate with every creature.” Closely related to this was the belief that she “could communicate with animals” and “could hear people’s thoughts.”

She has some evidence that, at one point, such communication may have actually occurred:

When I was in hospital in Israel, my friend came in to visit me and the staff was speaking to me in Hebrew, which is the language that they speak, and..um..they were talking to me, and she got really, really angry at them and said, wait a minute, she can’t understand..she’s from New Zealand. She can’t understand in Hebrew [laughs]..and they said to her, well, she’s been speaking to us..um..and understanding us in Hebrew for the last..for the last week. What do you mean, we just assumed she knew how to speak it. And that actually happened [laughs]..it’s not a delusion . . . um..but that’s one of those things that [my friend], you know, she tells people that all the time, ‘cause..she just thinks it’s incredible, you know [laughs].
Theresa also had experiences in which this sense of interconnectedness was closely integrated with a sense of profound meaning between things: “Everything..everything was kind of connected..like I would look at a piece of paper and it would tell me..um..um..something on there meant that I had to go to this place and..you know.”

**Channeling a child.** Throughout both periods of psychosis, Theresa had a variety of experiences related to giving birth, some of which were more removed from consensus reality than others. The longing to have a child and a family were present even prior to her psychosis, and she believes this longing fed directly into these experiences. During her first period of psychosis, while on the kibbutz, she had the sense that “if [she] was to have a child, it was to save the whole of humanity,” though she was not consciously trying to have a child: “I actually was trying to get pregnant on the kibbutz but not consciously (i.e., was pretty promiscuous and forgetting to take the pill).” During her second period of psychosis, this desire became much more prominent and in fact completely overtook her consciousness at one point:

The second time, I was actually consciously trying to get pregnant, i.e. had ideas that the creative moment would happen at a certain phase of the moon, with certain writing on the walls of my bedroom, and helped by particular crystals, etc. . . . I..completely sort of graffiti’ed the inside of my flat [with] all kinds of curly things [that] artistically expressed all sort of things to do with creation. I assumed I was kind of channeling..um..a child [laughs], that’s what was going on in my head, you know . . . . And strangely enough it worked – that is to say, I did get pregnant.

Even though Theresa’s experiences related to bearing a child were different in some ways between her two different periods of psychosis, overall, they were quite similar and they were also closely related to her experiences of universal expansion:

I had similar thoughts/feeling both times . . . that I was expanding and expansive to the point that there were no boundaries between me and the rest of the universe.
and the second time that I could bring about the healing of humanity by bringing all that is good into the spark that would create a child.

**Benevolent and malevolent watching over.** During Theresa’s second period of psychosis, she experienced what she describes as more “paranoid . . . type stuff,” a sense of being watched over by others with malevolent intentions. She describes one such occasion: “There was a van parked outside my place, and I thought that they were..um..I was being recorded and watched.” During this period of time, the sense of being watched over by others with malevolent intentions alternated with the sense that she was being watched over by others with benevolent intentions:

The kind of positive side of it was..um..being kind of watched over, I think, feeling like I was..like I imagined [laughs] there was a huge, great big strong..um..black man living in my wardrobe [laughs] who was there to protect me..um..but it was kind of like being taken care of, and..um.. as well as being kind of watched . . . [Similarly,] a dog came hanging around my flat and I thought, oh this is like kind of like a guard dog, you know . . . . So sometimes I would get really paranoid and, you know, pull out all the electrical..I don’t know, I think I remember pulling out the stereo and trying to destroy it and things like that; but at other times, I kind of felt like I was hidden away somewhere safe as well . . . . It was sort of like there was a strong kind of..um..yeah, protective kind of thing that would sometimes change around. I guess it was..it sometimes flipped over into a paranoia.

**Several different realities happening at the same time.** Theresa recalls occasions during her psychosis in which “several different realities . . . [were] happening at the same time – and . . . the boundaries weren’t clear at all.” She describes that this experience was particularly vivid when regaining contact with consensus reality:

The natural regaining of my 'normal' mind happened like that as well (and remember this was with no medication) . . . it was like the layers of 'other realityness' gradually peeled away to reveal a more 'grounded (or common sense of) normality' underneath and the more clearly the 'normality' came into focus the more I was able to realise what I needed and needed to do - another way to describe it would be like seeing something in a very clear focus . . . so you know that its real and then it gradually 'morphs' into another reality; as one starts to fade the other becomes clearer.
**Groundlessness.** Feelings of groundlessness pervaded much of Theresa’s experience during both periods of psychosis: “I didn’t even feel ‘physically’ connected to the ground most of the time.....or ‘psychically’ connected to the planet - and quite importantly (I think) didn’t feel connected to another human being thru pretty much the whole of the time.”

**Alternate characters.** For most of her life, even prior to and after her periods of psychosis, Theresa has had the anomalous experience of alternate characters, although she generally has not found this to be particularly distressing:

I don’t specifically believe in reincarnation (or not believe in it) but I have very strong feelings …and have had most of my life, that I have some distinct ‘characters’ within my ‘here and now’ being. Aspects of some of these popped up at various times quite clearly during my times of psychosis. One was a ‘middle eastern’ based character ……the imagery I get is veils, servitude, lush bedrooms etc (almost like being part of a harem of some kind) another is an Amazonian warrior type character (a man); very tall and strong, travelling long distances barefoot etc.

**The onset and deepening of psychosis.**

**Childhood isolation and insecurity.** Theresa recalls having experienced significant isolation in her childhood:

I think I probably had..a pretty cushy early few years..um..you know, until about four or five, and then my sister was born, and that was all okay, but I think all of a sudden, I kind of had gone from..I was the first grandchild in the family . . . so I was first of the children in the family, and..um..I sort of went from being the center of everybody’s attention to kind of nobody’s attention [laughs]. In the course of a normal type of life without other kinds of things layered on top, it probably would have been nothing, but I think what happened to me was . . . it was kind of a bit of a shock, you know, sort of around the time I was starting school which is quite an intense time for little kids, anyway..um..and so I kind of got this sort of sense of kind of disconnection almost that started right back then, you know..um..and then I didn’t make friends particularly easily at school.

She also experienced significant insecurity in her childhood:
Things started falling apart with my parents’ marriage [when] I was about seven or eight or something like that..um..and, so there was a lot of conflict and . . . things just started there and just went from bad to worse with their relationship and...never really recovered . . . . Mom . . . took us off and . . . then . . . she was just kind of on the move . . . . I went to more schools than I could remember..um..they had a couple of goes at getting back together so there was kind of all this kind of hope and stuff when they did . . . just that sense of stability, you know, maybe it will come back, you know [laughs]. But before the boxes were unpacked, they were fighting again.

Theresa believes that this continuous instability and insecurity further exacerbated her sense of isolation, creating “layers” of isolation and disconnection that ultimately contributed to the eventual onset of her psychosis:

Theresa: So, there was kind of just . . . layers and layers and layers of a similar kind of . . . you know, moving further and further into myself, I think, you know, and less and less able to trust..um..you know, what was going on around me..um..less and less able to trust them, as well.
Researcher: Right. Yeah, so really moving more and more into an isolated kind of experience of yourself and the world.
Theresa: And a sort of a disconnection, you know, like I..like not..not really feeling, you know, moving schools and not making friends, you know, and not really feeling connected..um..to anything, you know, so . . . it’s not difficult to see, you know, where those layers and things kind of come from.

Sudden death of both parents. Another significant layer to Theresa’s deepening sense of disconnection and ultimate vulnerability to psychosis came when both of her parents died suddenly in her late adolescence within just a few years:

Apart from those kind of early things, I mean, normally I think I probably could have survived and managed without, you know, developing psychosis . . . later on in my life, but then mom dropped dead and pretty much just suddenly dropped dead, as well. She had a brain hemorrhage, so..um..and it was so sudden that..yeah, our life kind of changed overnight basically..um . . . . I was sixteen so I was still in school, just at the end of school . . . so we moved . . . to live with my father . . . . It was completely miserable for a couple of years until I moved out ‘cause we hadn’t had a huge amount of contact with him and he was living with a woman that he’d been living with for quite a long time who we didn’t like..um [and] she didn’t particularly want us around . . . . And then four years after that..um..when I was twenty, dad dropped dead as well, pretty much . . . . So, I think, you know, the other stuff by itself might not have..might not have..uh, I don’t know, you know, needed such..um..an outlet that was quite so..extreme, you
know [laughs], but you know, the deaths and quite sudden deaths, particularly of Mom, were...yeah...were more than, I think, more than I could probably handle and not have it have to come out in some way.

**Suppression of painful feelings.** After the sudden deaths of Theresa’s mother and father, she believes that another significant layer covering Theresa’s connection to the world came when she received almost no emotional support for the tragedy of her parents’ deaths:

We had no...um...grief counseling of any kind...I think it wouldn’t have taken much, you know, at that point, but...um...you know, but I don’t even remember anyone saying, you know, how do you feel, you know, it sort of didn’t happen, you know...um, which means that everything pretty much, you know, all of those kind of layers, you know, just got pushed, you know, sort of further and further down and further and further in.

Not being provided with any less harmful way to work with the powerful feelings associated with the loss of her parents, Theresa turned to alcohol: “So I started drinking, which was...which was, you know, which was...fine [laughs]...I mean that helped sort of skip along the surface of those things.”

**Difficulty with self worth.** In retrospect, Theresa recognizes that yet another layer that was forming at this time was her difficulty with developing some sense of self worth: “[I didn’t feel] as important as everybody else or everything else around me.” She speaks here to her belief that perhaps one role of her psychosis was to develop that sense of self worth: “I seemed to need to...um...break through something to get to the point where I could sort of...allow myself to...I don’t know...um...to have what I needed somehow.”

**Overwhelmed by too much connection.** About a year after her father passed away, Theresa traveled overseas and ended up on a kibbutz in Israel. Except for a short break to visit her grandmother back at home when she became sick, Theresa remained in the kibbutz until the onset of her psychosis and hospitalization. She describes the kibbutz
as “a bit like my ultimate heaven”: “It was, you know, a big family feeling kind of place, a kind of..was communal living, kind of everything that had been missing..um..for me for a long time.” However, ironically, it was this very heaven-like quality that began to overwhelm Theresa:

Researcher: You were really able to get your needs for connection..in some way there, it sounds like.
Theresa: Well, yeah, like, yeah I did, but . . . I mean, that was kind of the problem, I think. It was all there, but I didn’t know that I needed that. It was..sort of having to recognize that, but I couldn’t..it was too..um..too intense to be able to do that, you know . . . . Because it was so..heavenly..um…it kind of brought to the surface all of the kinds of things that I’d been dealing with, or hadn’t actually dealt with….I was having a great time, you know, but I was sort of, you know, I mean, drinking..I practically just wasn’t sober, you know, and so..I sort of understand it like, it was all there but it was too much . . . it was overwhelming and I couldn’t cope with it, so I had to kind of suppress it the best way that I could, and..um..yeah, and then it..and then it just kind of bubbled through, you know, and..and just put me over [laughs].

The desire to have a family. Theresa believes that a common thread that lay at the core of many of her psychotic experiences was a strong desire to have a family, a desire that she believes was more or less unconscious prior to her psychosis but then came to full consciousness while she was attending a personal development course in the period of time between her two periods of psychosis: “[During] one of those courses, one of the early ones . . . you had to..um..make . . . some kind of vision for your life or create some..I think you had to make a promise or something like that, and mine was something to do with having a family or creating a family.” On one hand, the fact that this desire became conscious kind of surprised her:

I had sort of in my head, because I think there was..um..kind of grief and trauma associated with it, I had decided I was never gonna have children, and [laughs] . . . on one level anyway, I sort of thought . . . I won’t bother getting married and I won’t have children and that kind of stuff, you know.
However, along with this “strange promise” to herself came an important realization: “That was actually probably what I wanted most, but I couldn’t kind of handle it, you know.” When looking back on her earlier behavior, especially during the kibbutz, she recognized that this desire was probably very much alive but not fully conscious: “Maybe some of that . . . kind of behavior where you might get yourself pregnant, shall we say..um [laughs] . . . sort of was starting [at the kibbutz] as well.” Theresa believes now that, even prior to her psychosis, she may have been struggling with this core dilemma of wanting a family, yet not feeling that she could “handle it.” She now believes her psychosis may have played an important role in this regard:

Researcher: So, it sounds like there was a little bit of a dilemma in some ways between, there was some part of you that really wanted a family, and there was another part of you that felt like it would be too much or too hard, or..?

Theresa: Yeah, just, I don’t know, I seemed to need to..um..break through something to get to the point where I could sort of..allow myself to..I don’t know..um..to have what I needed somehow. Yeah. I think..maybe I had to be psychotic to make it happen.

Trauma from psychiatry. After several months of becoming further and further removed from consensus reality while at the kibbutz, the friend with whom Theresa had been traveling decided to take her to a psychiatric hospital. She found her treatment there to be more harmful than anything she had experienced prior:

I got sort of immediately assessed of being..um..deeply psychotic and was put on heavy medication, incredibly heavy medication, that knocked me out for about three days…And when I came to, I didn’t really recognize myself at all, and I couldn’t think, I couldn’t really do anything at all..um..and [I had], you know, one of those zombie kind of shuffles . . . . [I went] from someone who . . . was, you know, full of beans and…had a lot of energy and was, you know, like from one extreme to another. So..um..the trauma of that was probably..um..as bad as if not worse than the trauma of anything that had actually caused, you know, what I now kind of have come to understand is what caused the..um . . . . the breakdown..or whatever, in the first place, you know.
In retrospect, she acknowledges that she did need some kind of strong support, but not
the kind of support that the hospital provided:

The unnecessary bit [was] being pumped full of medication and being knocked
out cold for three days . . . . Although, having said that, I meant that was
completely unnecessary..um..I did need some kind of help. I did need a safe place
to be because I don’t quite know what would have happened if someone hadn’t
have grabbed me, but..um..I didn’t need that extreme level of kind of interference,
you know.

Theresa believes that even her friend had been significantly traumatized by the hospital
experience: “My friend . . . who’s still my friend actually, was..um..I think probably
more..she was as traumatized by the whole hospital experience as I was, and..um..so
that’s taken her a long time to work out as well.”

Much later, near the end of her second period of psychosis, while homeless and in
dire straits, Theresa made one more desperate attempt to get some support from a
psychiatric hospital. Ironically, this time, rather than using forceful interventions, they
completely turned her away:

I needed some help, so I went to Ward 10 of Auckland hospital . . . which was the
psych ward, and tried to present myself there, tried to say, look I’m not well and
need help, that I kind of needed more help to deal with my physical symptoms,
really, I mean mentally I was kind of okay..um..and..um..but they said, ah, well
sorry, if you’re..um..well enough to tell us that there’s something wrong with you,
you know, you’re not unwell enough to be here type of thing.

**Her process interrupted by antipsychotics.** After being released from the hospital
in Israel during her first period of psychosis, Theresa returned home, where she lived
temporarily with some relatives and remained on a heavy dose of antipsychotics. About
four to six months later, she moved into her own place and completely stopped taking the
antipsychotics, and about two years later, she entered her second period of psychosis. In
retrospect, Theresa believes that the antipsychotics did play a major role in stopping her
psychotic experiences during her first period of psychosis; however, she believes that this
did not ultimately serve her at all, since it merely interrupted a process that needed to be
completed:

The way I understand it now is that the first [period of psychosis] kind of got
interrupted, you know, with..well, with the drugs, with the medication..um..and so
the whole process just got stopped, basically. Um, you know, what it was that I
was working through and needed to work through was..just kind of got halted . . .
. The purpose that it had, that it was serving, to work through those things that we
were talking about before, the trauma and stuff, didn’t have a chance to..to come
to a natural kind of conclusion or fruition or whatever, to evolve to where it was
needing to be, so..um..so I mean, you know, I sort of think of it now as if you
don’t have the chance to work something out, it’s gonna come out in some other
way, you know.

***Pushing herself to the limit.*** About a year after returning home, during what
Theresa now believes was essentially a latency period between her two periods of
psychosis, she attended some intensive personal development courses:

They were slightly cultish really in a way that they..um..you kind of did these
weekend workshops and..um . . . they encouraged you to kind of surround
yourself with people who want you to win and all of this kind of stuff . . . and they
cost thousands and thousands of dollars . . . . So I kind of got into that and then
ended up..um..becoming very..well, becoming kind of what I thought was quite
connected to the people that were there, and I probably was, but I did isolate
myself very much from everybody else.

During the final course, which was particularly intense, both physically and
psychologically, Theresa felt herself begin to slip away from consensus reality and
eventually into her second period of psychosis:

The final course that I did was..um..a weeklong intensive thing where you go off
in the bush..um it was called breakthrough, and break through your mental and
physical limits of the things that you think are possible in your life, and that’s the
idea of it, and..um..uh..so I wasn’t drinking or doing anything like taking any
drugs but I..um..I did use..um..kind of..what I now understand to be kind of like
mind control techniques really, sleep deprivation and intensive
physical..um..exercise and stress and things like that, and um I slipped sort of
slowly into another..um..mental crisis, I suppose you’d call it..and..um.[soon]
became what would be defined by psychiatrists probably as intensely psychotic again.

Recovery.

Relief via normalization. Even though Theresa believes that most of the deeper work that was taking place within her psychoses had been temporarily paused during the latency period between her two periods of psychosis, she does recall one event during this period that she feels ultimately played an important role in her recovery:

When I came back from the kibbutz...um...there was a social worker that came to visit me...and he had this list...it must have been a kind of an assessment list, you know, did you sense you were, you know, the second coming, and do you believe bla bla bla, trying to get a handle, I think, on what kind of...psychosis or whatever...But it was a huge relief for me, because I sort of was like, oh my, yes I did, you know, feel this, or, no, or whatever, but it sort of said to me that...um...that I wasn’t completely alone in having these experiences...you know, I’m not a total freak...There was quite a...quite a relief in that. That that was one of the things...um...you know...it really, really stood out, you know.

Pregnancy. During her second period of psychosis, the desire to “channel a child” became very prominent. She did in fact get pregnant, and this became a major turning point towards recovery:

Before I slipped into, I guess, being...in a state that probably people couldn’t have related to me at all...very easily, I...um...decided that I was going to have a baby...yeah, and so I...you know...had a very brief relationship with an old...school friend, and got pregnant.

Theresa continued to struggle with psychotic experiences and even some serious hopelessness for some time after discovering she was pregnant, but she realizes now that this point represented the lowest point in her psychosis, after which a number of important events continued to unfold, leading her eventually to full recovery. Looking back on the entire process of psychosis and recovery, Theresa has come to believe that
pregnancy was not only a major turning point, but also a major part of the ultimate goal of her psychosis: “It was the beginning, really, in a way . . . because I mean that was the beginning of creating a family . . . . which is kind of where it was all heading, I think.”

**Hitting bottom.** Theresa was now pregnant; however, she was also homeless and completely alone. She had just been evicted from of her apartment, had spent the night in a homeless shelter, and found herself contemplating suicide:

> I was walking across Grafton bridge where people coincidentally quite often throw themselves off...um...and I sort of thought, okay, you know, considering what’s ahead of me, and, you know, what’s just happened, being dead would be easier than this, you know, so like, I mean, I wasn’t thinking I’m gonna kill myself but I was thinking, you know, being dead would actually be easier than this, considering . . . I didn’t have any support . . . . But then I had that kind of thing . . . that quite a lot of people described, well, you know, the situation is as bad as it could possibly get, you know, the only way’s up [laughs] . . . . so just take the next step type of thing.

**Finding refuge with psychiatric survivors.** Whereas her revelation of having “hit rock bottom” on the bridge had given her some sense of hope that things could not get any worse, she still was feeling quite stuck: “There wasn’t really any ‘agency’ in that – it was just a resignation that I had to put one foot in front of the other.” Fortunately, soon afterwards, she came across a drop-in center run by a group of psychiatric survivors, an encounter that represented another important turning point:

> I just wandered in. I was still actively psychotic (i.e. was having uncontrollable disturbing visions/thoughts...but mainly fears for my sanity, fear of being under psychic attack, etc.). I think I was beginning to regain my sanity and realize the situation I was in and was starting to recognize when I was in touch and out of touch with ‘normal reality’. The place had a self contained room – think they called it ‘emergency accommodation’ where I stayed for a week or so. Despite the stuff that was going on in my head, I actually felt safe there . . . .and in all the time I was wandering and psychotic (that time) I hadn’t found anywhere I could just stop and feel safe......(which was something to do with the striving I think). If there was a point where my recovery started I guess it would have been there...I had the chance to stop and take a breath, gather my strength, and I realized I
actually had the strength to face what lay ahead… I found my own internal hero… then funnily enough I met a real one!!

*Meeting a supportive partner.* After being pregnant for about three or four months, Theresa met a man who began to look after her: “I was, I don’t know, a little bit strange and a little bit interesting and still pretty..um..still pretty mad, but..um..he kind of took me under his wing, really..um..and fed me because I was pretty much homeless and pregnant, you know [laughs].” Theresa describes a particularly important aspect of this man’s character was his groundedness:

He actually seemed totally connected to the ground, and also not in even the slightest bit scary.....or like he would try and make me do anything I didn’t want to do, etc......I was so "tired" (in every sense of the word ) by then, that at that point the ground (with him on it) started to look pretty good.

The stability and care that he provided were the final important resources that Theresa needed in integrating her psychotic experience, returning to consensus reality, and successfully raising a family: “That quality of just accepting and respecting each other for who we are and how we feel/what we believe, etc., is something that has continued into our relationship and is one of the keys to our success, I think.” They remain together to this day over 25 years later.

*Integration through psychotherapy.* Shortly after meeting her husband, Theresa’s psychotic experiences essentially disappeared. However, she found that it was important that she continue the process of integrating what happened. Beginning about ten years ago, she attended regular psychotherapy sessions for about six years and found this to be very helpful.
Lasting personal paradigm shifts.

A deeper sense of interconnectedness. One of the core threads that ran through many of Theresa’s psychotic experiences was a profound sense of interconnectedness. To this day, she continues to appreciate the principle of interconnectedness, although she no longer feels it with the same intensity and certainly not with the same degree of confusion or distress that often accompanied it during her psychosis:

I have had lots of moments/times of experiencing [interconnectedness] since then. Before, because it was in the context of such a lot of other strange thoughts and feelings (and reactions of others made me feel there was something wrong about it), I had to immediately translate the experience (feeling) into something tangible – as it felt so out of control – which might be why I saw some of the things I did and believed I could read people’s thoughts, etc… whereas now when I have that feeling/experience (which I do periodically) I don’t need to find any kind of framework to fit it in – it just IS and I can just BE – it’s pretty Buddhist, from what I have read ….and if there was any kind of spirituality I subscribe to now I guess it’d be close to some of that.

Seeing her psychosis as a necessary process. Theresa has come to believe that her psychosis had important meaning: “It’s not . . . [that] the particular crazy ideas had a kind of a meaning, I can kind of see what purpose they were serving, where they were driving me, you know.” She believes that the purpose of her psychosis was ultimately to transcend her isolation and inability to meet her needs:

I mean, [the psychotic experiences] were..they were fulfilling..helping to fulfill or drive me to fulfill needs that I’ve had for sort of forever . . . . We do try and meet our own needs . . . and if you’ve gone through quite a lot of trauma, you know, the way that you try to meet your needs, to me, couldn’t come through a normal channel, you know . . . . And I think it was that interconnectedness to anybody, you know, or anything, that I was desperately craving, you know, and so I kind of experienced this kind of connectedness.

Closely related to her desire for connection was her desire to have a family, and she believes her psychosis played an important role in first making this need conscious and then healing and transforming her at the depth necessary to give her the necessary
capacity to fulfill this desire: “[In the personal development course,] you had to . . . make a promise or something like that, and mine was something to do with having a family or creating a family, so…I think..maybe I had to be psychotic to make it happen.” Theresa believes that because of her lack of other resources, it had become necessary for her psyche to resort to such a “desperate strategy”:

All that stuff was just very buried, and, you know, I never had any grief counseling, never spoken to anyone, you know, I mean I’ve read a bit but not a lot really, never had any counseling..um..you know, so I didn’t have any kind of tools to be able to deal with any of that, so..um..it was kind of . . . my own clever kind of tool, I think, of..of breaking through and dealing with it.

Through her own process and having now worked within the mental health field for a number of years, Theresa has come to believe that the mainstream psychiatric treatment of the heavy use of antipsychotics is generally a detriment to the successful resolution of psychosis: “I’ve been and worked with people that are intensely psychotic, and you don’t have to knock them out . . . . I didn’t need that, I didn’t need medication at all, I don’t think anyone does, actually.” Instead, she has come to believe that the most important things for supporting someone suffering from psychosis is safety and acceptance: “All of this makes me feel so sure that the things people need at times of intense mental distress . . . are just so simple and basic. We just need to feel safe and have someone we can trust who won’t judge, tell us what we should or shouldn’t be feeling or thinking, but just accept what’s going on for us and ask how they can help.”

Loosening her attachment to her thinking mind. Throughout her journey through psychosis and recovery, Theresa has gained insight into how cerebral her general way of being in the world was: “I kind of lived in my head really, I mean, I didn’t really feel, you know what I mean, like I used my brain to think everything out.” She has
developed ways to loosen her attachment to her thinking mind somewhat and balance her experience with other ways of being. One way has been to reconnect with her body:

I wasn’t really very connected to my body..um..so, I’ve done a lot of work, I mean I’ve been doing yoga for years and years and years now, you know, and I’ve done a lot of kind of work on actually . . . just feeling, you know, and expressing my feelings rather than channeling everything through my brain, you know.

Theresa has also used art as a way to connect with other realms of her experience. She believes art may have been helpful in detaching her from her obsessive mind during her psychosis, and it has helped her to remain connected with her creativity since:

I think [art] was kind of an outlet for all the feelings I was having that I couldn’t understand with my mind. Art, for me, comes from a subconscious realm, which cuts through my usual tendency to ‘think’ things to death….however, there was a drive and a desperation about [my thinking] when I was psychotic –  a seeking to understand. So [art] probably did help in some way. Now I’ve discovered that I can tap into that same creativity….and the more I do that (just relax and let it be) the more ‘critical acclaim’ [my art] seems to get.

**Learning the value of validation.** As a result of her process, Theresa has learned to greatly appreciate the value of accepting and validating others’ feelings and experiences: “I want people to be accepted. Yeah, I want their, you know, experiences to be kind of validated, and I want people to listen to them, you know, in the same way that I want to be listened to.” She has since made an effort to connect with others who share these same values: “The people that I connect with now I guess are people that..um..that are kind of validating, I suppose . . . sort of the kinds of people that will accept and acknowledge your experiences and just accept you the way you are, you know..um..yeah, those are the kind of people I’m drawn to, I suppose.”

**Appreciating different layers of experience.** As mentioned above, Theresa had times during her psychosis when she experienced distinct layers of experience. Even
though she has not had psychotic experiences in a number of years now, she continues to appreciate a certain validity to seeing our experience in this way:

Actually I think life is like that for everyone all the time really...it certainly is for me - like those times when you feel yourself transforming but the transformation is so slow that you almost don’t notice it till you catch maybe a shadow of something you used to be as it slips away forever and you become something new....I have that experience quite regularly.

**Lasting benefits.**

*Increased sense of peace and balance with her feelings.* After coming through such extreme experiences, Theresa’s experience of her feelings has changed significantly. She believes she has always experienced a very wide range of feelings both before and after her psychosis: “I can’t imagine how I could ‘feel’ any more than I already do/or did before my psychosis.” What she feels has changed, however, is her relationship with her feelings. In particular, she now experiences a greater sense of peace and balance with her feelings:

I have actively sought to reign in my emotional rollercoaster world a bit - that is I’ve sought for more of an "even keel," rather than being tossed around with the heights and depths of my feelings - I’ve tried to find more of a sense of peace and balance - which I definitely have....and I’d say that I don’t think that would have happened without the psychosis/journey I’ve been on.

Closely related to this is that she no longer fears being overwhelmed by her feelings:

[Now, I feel] like I could let go without feeling afraid I’d be overwhelmed by emotions....I did definitely have times of being overwhelmed by emotion - and still do, I guess, but I don’t have any fear now that I won’t be able to handle it....that anything bad will happen, or that I’ll hurt anyone else (or myself).

*Less fear of the unknown.* Theresa feels that, as a result of her psychosis, she no longer fears the unknown: “After having been in a kind of ‘ultimate bliss’ state and also in an ‘ultimate terror’ state, I guess there's no fear of the unknown for me anymore.”
**Greater self acceptance.** Theresa has developed a much greater sense of self worth and self acceptance than that which she experienced prior to her psychosis. She gives one example of how this manifests in her life:

You know, my husband used to joke about that I would..um..tell strangers at the bus stop my life story if I got the chance, you know. Um..I went through quite a few years of kind of wanting..wanting people to know everything about me, but I think it was so that I would be accepted, you know. ‘Cause if you know everything about me, you know, and you’re still okay with that, you’ll kind of accept me, you know, and you’ll think I’m okay, you know..um..but when I started to feel like I was actually okay myself, you know, I kind of didn’t need to do that with that kind of, you know, desperation.

**Less effort in relationships.** One other lasting benefit Theresa ascribes to having come through her journey of psychosis and recovery is a sense of much greater ease within her relationships:

[Prior to the psychosis,] my relationships operated in a very unconscious and knee jerk reaction kind of way. I felt at the mercy of other people, so for example in personal (romantic) relationships, [I] would bolt at the first sign of trouble, rather than stopping to figure out why I reacted the way I did and what my part in this is…..and [I] also didn’t really think I deserved to be happy. I don’t really put what feels like effort into relationships now. By that I don’t feel obliged to have relationships or do things for people just so they will like me. I feel like a worthwhile person now so don’t have to ‘try hard’ to be anything I’m not….I felt for a long time that I was putting ALL the effort into all my relationships and never getting anything back for myself. Now I think that was probably because I didn’t think I was truly worth it.

**Lasting harms.**

When asked about any lasting harms she might still experience as a result of her psychosis, she adamantly responded that she could not think of any: “No, nothing, nothing, nothing [laughs]. Nothing bad came from this [laughs].”
The Case of Byron

**Brief biographical sketch.** Byron is a 59 year old Caucasian male. At the age of 19, he suffered a sudden onset of severe psychosis that lasted for about six months. He was diagnosed with schizophrenia and hospitalized for nearly all of those six months. He was first hospitalized in a private hospital, but when his insurance ran out, he was moved to a state hospital, where he often received severe treatment including spending time naked in a cell with no toilet. He was placed on antipsychotics including thorazine and stellazine while in the hospital, but he discontinued the use of these drugs after leaving the hospital, and he has remained completely free from them for the approximately 40 years since. For the past ten or so years, Byron has been working in the mental health field, first as a psychiatric aide and now as a spiritual support facilitator.

**Description of the anomalous experiences.** Byron’s anomalous experiences consisted primarily of visions and powerful experiences of being on a hero’s journey, many of which involved themes of death and rebirth or other mythological and/or archetypal themes:

*Visions that closely parallel Tibetan Buddhist themes.* Strangely enough, long before encountering Tibetan Buddhism, Byron had a number of visions with themes that he later came to realize closely match those found within Tibetan Buddhism:

It’s really remarkable how many of the visions I had during my psychosis have found context in Buddhist practices . . . . None of that stuff was available at the time, I mean to me, you know, it was all in Tibet, it wasn’t in this culture . . . . Most of these contexts fall in with the Buddhist tantra teachings. Over forty years ago, while in the state hospital, I experienced many visions and non-ordinary thought processes such as transforming poisons into nectar, liberating suffering beings, performing rituals for world peace, visions of charnel grounds, and much more. The visions I experienced have not gone away; rather they’ve found context and place with my Buddhist practice.
Visions of transition. Byron had numerous visions with themes of transition. Among the strongest and most coherent of these ha striking parallels to the Tibetan Buddhist concept of bardo, a Tibetan word meaning intermediate state. In Tibetan Buddhism, the term bardo refers to the transitional state between the ending of one life and the beginning of another. Byron had a number of experiences that he described as feeling like being “in between” different realms. He had one long visionary experience in particular in which he felt himself to be in bardo:

I descend through dimensions of energy experiencing symbolic correspondences like astrological planetary energies, colors, chakras, and strong kinesthetic feelings. I move down level after level. As I move down to each particular level, I encounter a person who I have known in this life. This person typifies a level of incarnation. I recognize that in being on this particular level, this person has assumed a certain level of responsibility. Each level is an entire horizontal world existing on a vertical axis. The vertical axis maps onto planet Earth. I descend into the center of the earth. There are female entities in attendance.

He now recognizes these female attendants as dakinis: “It’s a Tibetan term meaning ‘sky goers.’ These females show up in your life to guide you.”

Another commonly recurring theme within Byron’s visions was that of “the transition of the ages,” which often tied in closely with “the great battle between the forces of good and evil” and the battle between wisdom and ignorance:

So..so I’m living in this whole world along with the..current images and symbolism, you know..like the Beatles and Crosby, Stills, and Nash, all the imagery from that all came along, and then people talking to me across the TV, and I’m seeing the great battle between the forces of good and evil, the transition of the age..the age of Aquarius..and I feel like I’m involved with this, that..um..you know, we’ll either go back to the Stone Age or we’re going to..um..go into the Aquarian Age with a major shift in awareness, planetary awareness. And..um..so I was kind of in that place for most of my psychosis.

A hero’s journey. Byron experienced a number of visions in which he experienced himself as a hero. During his first hospitalization, he was taken to a private
hospital at the suggestion of his therapist at the time: “I ended up at a private hospital for
. . . . I thought I was going to ..um..a kind of a retirement center or . . . special place
where ..um..people who had attained the awareness that I thought I had would go.” After
about three weeks, he was returned home, but hospitalized again shortly thereafter. His
insurance soon ran out and he was transferred to the state hospital, where his sense of
being on a heroic mission intensified:

They put me in the old-style state hospital, which I would end up in a cell..either
stripped naked in a cell with no bathroom for..but, I was in these extremely
altered states, and it was all part of the process. In fact, in the journey from the
private hospital to the state hospital, I felt like I was going into the regions of hell
to rescue all the beings . . . . I had experienced heavens and hells, and this had the
distinct sense of going down from the heavens into the hells..and then to free the
prisoners and hospital patients.

At times during this process, he literally had visions of taking the world upon his
shoulders: “I had distinct experiences of being Atlas taking on the world…taking the
whole planet on my shoulders, handing it off to Heracles and back. All these myths came
alive and were personified.”

Groundlessness and disintegration. Byron describes experiencing a profound
loss of any sense of ground during his experiences: “My ground was fairly decimated. I
had little or no grounding reference points for my experiences. The experiences were like
rivers of non-ordinary dream states that carried me along.” Along with the sense of losing
any semblance of solid footing were experiences of the disintegration of his self. He
describes one particularly poignant example of this: “One of my big visions was of being
cut into pieces, a very vivid sense of being on a dissecting table with several doctors
dicing me to bits.” Finding peace with the experience of groundlessness and the loss of
solidity would prove to be an important aspect of Byron’s recovery.
The onset and deepening of psychosis.

Childhood seeds of isolation. Byron believes there were some aspects of his childhood that may have predisposed him to his psychosis—in particular, his close relationship with an eccentric mother and, closely related to this, his own sense of isolation:

The precursors of [the psychosis] were significant, I think, in terms of my growing up. My mother was an artist and experienced things in kind of a surreal way..um..and I was very close with my mother, and I..um..so that affected me a lot . . . . My mother was very..um..nonordinary in her artistry, very surreal and kind of..um..interesting..images, and I was in that place, you know…around my childhood. And in adolescence, it was like, you know, now it’s time to operate in the world as a functioning member, and I had a hard time with that . . . . [I then had] a very troubled adolescence [that] affected me a lot, I held a lot inside. I was pretty intelligent, I was put in a class with, you know, other intelligent people, but it was also they were all from the same..uh..culture and group, and I was sort of the outsider with that mix, and..um..I took everything very personally . . . . I had a very hard time with that, and I really didn’t want to be here so much.

A profound sense of connection as a child of the 60’s. Byron identifies somewhat as a “child of the 60’s,” and he feels that the sense of liberation and deep connection related to this also played a significant role in the onset of his psychosis. In particular, at Woodstock, just two months prior to the onset of his psychosis, he experienced a profound unitive experience facilitated by hallucinogens and the nature of this once-in-a-lifetime gathering of people all wanting such deep connection: “I was feeling incredibly ecstatic, waves of bliss coursing through my body. Every cell in my body exploded in bliss. I felt that I was on a heavenly plane of experience, I felt tuned into multiple dimensions simultaneously. Every desire was satisfied, there was want for nothing.” Byron believes that this experience played a significant role in the onset of his psychosis just two months later: “At Woodstock I had a transcendent experience. I believe this was a contributing factor to my going off the deep end two months later.
Why? Because the experience was so powerful. I actively sought connections with these kinds of experiences."

**A rebirth process.** Shortly after Woodstock, Byron went through a series of incidents revolving around a strong desire to undergo a profound transformation. In what would become a major turning point, Byron spent an entire evening in his apartment, performing a shamanic rebirth process:

*Byron:* There was a number of events, but then everything sort of came together and I felt that I was gonna die and be reborn. In fact, I was sort of living the experience of death and rebirth, and I did this all night journey which was very intense. I tried to turn myself inside out, trying to die and be reborn. Have you ever read any of the shamanic stories--?

*Researcher:* Some.

*Byron:* --about death and rebirth . . . . I was like flashing on dying and being reborn in the womb, I was flashing back and forth between these themes to converge to where I would take a rebirth as a new form . . . . And then at the dawn I felt like I had transcended, perfected going into the future, and I kind of..uh..faded off, then I walked off the balcony three stories and broke every bone in my skull.

*Researcher:* Wow. Was that intentional or accidental, when you walked off the balcony?

*Byron:* I have no conscious recollection of that whatsoever.

**A severe head injury.** After his profound rebirth process followed immediately by falling three stories off of his balcony, Byron awoke in the hospital with a severe head injury and experiencing “extreme altered states”:

I was in the emergency room in a hospital in Boston, and first thing I remember seeing my brother walk in and fainting when he saw me..tubes hanging out [he gestures toward the right side of his face]..and I was in extreme altered states, and the altered states continued, so I was having all these nonordinary experiences increasing..um..leaving my body..come back in..go out and come back in.

P: You probably had some brain damage at that point, or..?

B: No, that was never determined. I was extremely fortunate to have retained my functionality. So, um..anyway, I did survive [laughs]. I don’t know if my psychosis had aspects stemming from brain damage or not because it all came on before the incident, so..my best consideration is it had multiple causations, you know, it was not just one thing.
**Taking on more than he could handle.** After waking up in the hospital, a visionary process began to dramatically unfold:

My initial experience was of...um..really transform...everything broke through, and it was like all my sort of...um..angst and questions came pouring out into this powerful energy and I experienced everything in sort of like dream states 24 hours a day. Not unlike some of the psychedelics but much more powerful. It was...um..a full..um..enrapturing experience, if you will, and..uh..I mean it was...um..I experienced a whole lot, there was major themes of death and rebirth and of..uh..birth of the Aquarian Age and of the eon..um..I was always absorbed with the quest of meaning for me, so some things seemed to click into place big time, but it was all very much three dimensional dreamlike. The television would be talking to me, people on the TV, and..um..some of the dreams were intensely significant which I remember today which actually are part of my spiritual practice.

It was during this period of time that Byron underwent the bardo experience with the dakinis accompanying him into ever deeper realms. Byron’s eagerness for transformation (both for himself and for the world) continued in spite of his serious injuries, and he recognizes now that this eagerness resulted in him taking on much more than he could handle. Even though Byron was cautioned by the dakinis about going deeper and taking too much on, he continued:

So..um..I really..I went further, I went lower each level . . . I say to these entities that I want more and want to go deeper. I want it all. [They respond], you know, you’re asking for it all, you know, it’s like, do you know what you’re asking for, and I really didn’t, I really didn’t, but I was insistent that I wanted to take it all on. I was so insistent, so...I took on all of it, you know . . . . But I cannot handle it all . . . . After asking for it all, there comes a time when I must take on the responsibility and burden of what I have asked for. There is no way I can handle it. Did you ever see *Fantasia Sorcerer’s Apprentice*? Mickey Mouse, when he takes hold of the wizard’s implements and then conjures up all this stuff, that’s what happened to me. I couldn’t handle it. Or the flight of Icarus. It was very much that.

**Being poisoned by antipsychotic medication.** Byron was heavily medicated with antipsychotics for the six months that he was hospitalized, but he stopped taking them as soon as he left. While he does acknowledge they probably provided some kind of
grounding, he did not find the kind of grounding they offered particularly helpful and, overall, he considered the medication more of a hindrance than a benefit in his recovery:

Byron: Um..the drugs to me were poison, you know [laughs]..I won’t take them. I’d rather be in a jail or something.

Researcher: Right. So, it sounds like overall you felt the drugs were more of a hindrance than a benefit in your recovery.

Byron: That’s why [John] Weir Perry did outstanding work. He had no drugs at Diabasis house and the staff was instructed to allow people to go through their experience no matter how bizarre it was, ’cause there was kind of a certain element of safety, you know..that’s what I needed.

Recovery.

Washing to the shores of consensus reality. After being hospitalized for about six months, the intensity of Byron’s visionary experiences began to calm down and he found himself in a cyclical process while reconnecting with consensus reality:

I had images of washing to the shores of consensus reality, I mean I was going through these cycles and the cycles of experience sort of lost their spark, if you will, and..uh..because these cycles, they became tiring in a way, and I was heavily medicated, which added to the mix, and it was kind of difficult, and then, you know, I was like…I didn’t, you know, it wasn’t an epiphany of reconnecting to planet Earth because actually, you know, in a way, those places were my real home . . . . It was like everything kind of wound down, and then I was suitable for discharge after about six months.

Struggling to find meaning within mundane existence. But after discharge, Byron found himself struggling deeply with finding meaning in mundane existence.

Samsara is a Sanskrit word that refers to the cycles of existence and is commonly used in Buddhism, Hinduism, and other Indian religions. It refers to both the cycles of life, death, and rebirth (i.e., reincarnation) in which most of these religions believe, but it also refers to the cycles of existence within a given life (e.g., wake up, work, sleep, wake up…; eat, defecate, eat…), and it often implies the challenges of finding meaning in this cyclical existence. Byron recalls his own struggles to find meaning within Samsara:
Byron: And..uh..so there I was, you know, and now what. Now what. You know, how do..what do I do, you know. Nothing that was part of this world really had any attraction for me, you know, like what do I do, how do I find a reconnection, I didn’t want to go back to the state hospital, or go back to that place where everything was unavailable, but I was sort of in an in-between place still. So there I was..um..what now, what next. I hung out with some old friends but I couldn’t really reconnect, you know, there was very much, what now. I enrolled in college, I’d gone back to school, but it didn’t hold the spark.

Researcher: Yeah. So, it sounds like you were having trouble finding meaning in sort of consensus reality, or to use Buddhist language, Samsara, the realm of Samsara?

Byron: Exactly. Exactly. Samsara actually all my life was very uncomfortable for me…

Researcher: So, even before these experiences, it sounds like you were having a hard time finding a real sense of meaning and richness in kind of mundane existence, in the mundane world.

Byron: Right.

Researcher: And then after the experiences, that really returned, that same, how do I find some meaning and connection with this Samsara, this mundane world.

Byron: Yep. And..uh..where do I go from here, and..uh..but it was very fine because one of the images that came was..um..that it was gonna be a long time before I found my integration, and..uh..it then took decades before I really connected with my home which is Tibetan Buddhism [laughs].

**Finding spiritual guidance.** As Byron was struggling to find meaning in mundane existence, he came across Ram Dass’s book, *Be Here Now*, which inspired him to find a teacher: “That was a major book. I absorbed it, you know. It was like I read it cover to cover right away, it talked to me, and..uh..how do I find my guru, how do I find my teacher?” It took Byron another thirty years to connect with a teacher and a teaching that really resonated with him, for which he is deeply grateful: “Over the last ten years . . . I picked up the Tibetan Buddhist practices . . . . I have a wonderful teacher now, born in old Tibet and all that [laughs] . . . . That’s how I found my ground after all these years.”

Byron believes that his contact with spiritual teachings and teachers has played an invaluable role in his recovery:

The psychosis alone did not produce the positive changes I experience today. The changes happened over many years conjunct with spiritual practices . . . . I’ve
been very, very fortunate to connect with wisdom teachings from teachers and authentic spiritual masters. The blessings of the masters and the practice of the teachings have made tremendous difference in my life. Without these influences, I don’t think I’d be in a very good place today if I was here at all.

One teaching that has been particularly important for Byron is “the two major principles identified in Buddhism as wisdom and compassion. They are seen as two wings of a bird. One without the other is not sufficient. A bird to fly needs the two wings to work together.” Byron has worked hard to integrate these principles in his recovery. He offers one particularly poignant example here:

It’s interesting that one of the major vision/hallucinations I had was of a very prominent infinity sign in the sky. One loop was blue, the other red. I understood that I had experienced the one part, perhaps the blue. It was my task to integrate the red loop through the subsequent years of my life. I had tremendous visionary insights in my psychosis. I could, however, do nothing with them without grounding in areas of love and compassion. Again, I’m still on this journey.

Grounding the nonordinary with meditation. In the thirty years prior to finding his Tibetan teacher, Byron practiced a number of different types of meditation, first picking it up during a visit to India. He feels that meditation has been very helpful in his recovery:

I feel that that grounded me over the long term . . . . It’s actually grounding the nonordinary, it’s actually working with your own mind and the very subtle influences that come on over time that, you know. It really is a transition type of thing, ‘cause that was my sort of...um...refuge and resource, the meditative experience.

Using mandalas to bridge the collective unconscious with the personal. Over the past ten years, Byron’s meditation practice has transitioned to those practices that are associated with Tibetan Buddhism Even though he has no longer been having psychotic experiences, he finds that these practices play an important role in his ongoing healing and growth:
The Thangkas or the images, the mandalas, the peaceful and wrathful deities, all of them—to me, they’re, you know, living archetypes of...um...in the Jungian sense, they’re in the collective unconscious, but they become very personal, as well. Those images...really fit...Mandalas really are forms for understanding the universe, so...that’s what I’m very involved in, and for me...for me it was a godsend.

**Lasting personal paradigm shifts.**

**A richer and broader experience.** Byron has found that “his general experience is both richer and broader” than prior to his psychosis. “I’m learning to pay attention to what shows up. I’m learning to enjoy what shows up. I’m learning to accept the difficulties and to apply the [meditation] practices.” He describes that the various anomalous and psychotic experiences he had increased the spectrum of his available experiences, but that ultimately it was his discipline and the “trainings” that played such a major role in his recovery that allowed him to integrate and develop mastery over these feelings. He wrote:

The epiphanies and powerful experiences of my life were doorways into rooms other than the confining egoic experiences and addictions I had assembled in my life. The thing is, you may open the door and enter a particular alternate state, but this is often only for a short time. You need to come to terms with the arrangements of rooms, doors, keys, etc. Life is like a funhouse with many rooms. (joke)

**A greater capacity for and enjoyment of presence.** Byron expressed having struggled all his life to find satisfaction in mundane existence. However, since his journey through psychosis and recovery he finds that he has developed both a greater capacity to be present and a greater enjoyment of being simply present and alive: “The major theme is about being present now and being very happy to be alive and grateful for the opportunities that happened... I’m on this continuing path and, you know, in whatever time I have left, I want to intensify that process.”
Interconnectedness and emptiness. When Byron speaks of the “real reality,” he has come to believe that our experiences and the manifestations of the world are not solid and tangible in the way that is typically accepted within consensus reality. As a result of his own experiences, Byron has come to experience the world in a way that he realizes now is in close alignment with the Buddha’s teachings:

Byron: [All manifestations] arise out of this whole web of interactive causes and conditions, and that’s..I mean it’s very inter-, it’s no simple thing, it’s very vast, and that’s…another aspect of my understanding. It’s not like about me, about, oh, I have these realizations, at all. In a way, I’m just like this small mound of skin in a big ocean of existence, and yet I also have, you know, some insights as many others do as well, you see. That’s really wonderful and amazing, it’s simultaneous, you know, connected with..I’m a part of it all, I’m even one with it all, so each of us is, each of us is, you know, nobody’s up and down, you know. Researcher: So, in everything you’re saying, I really get the sense of how interconnectedness has become such a..such a strong part of your general experience of the world and your self now.

Byron: That’s the nature of reality, ultimately speaking, there’s nothing that exists by itself, it’s all dreamlike...and that’s the Buddhist precept...and that’s something to think about, you know, that’s…the wisdom of emptiness.

A less solid sense of self. Just as Byron has come to see all manifestations of reality as interconnected and ephemeral (i.e., empty), he has also come to experience his self in a very similar manner; and again, his own experience in this regard is in close alignment with Buddhist teachings:

So, self is not a discrete independent object but a process, actually. I mean there is someone, according to Buddhism, that transmigrates through space and time, through lifetimes, but..um..um..you know, the self itself, it’s all dependent, dependent on how we conceptualize self, dependent on so many factors, upbringing and all that, and things can change, so there are some common themes that I’ve continued in this lifetime and will probably continue wherever I go, but this sense of self I have now is..um..um..a much happier and..um..I do have the sense that it’s not so solid, you know.

Expeditied settling of karmic debt. Byron believes that, as living beings, we collect karmic debt, consequences of all of our actions that remain with us and must
ultimately be worked through and resolved. He has come to believe that his psychotic process provided him with a means to resolve much of this karmic debt in an expedited (albeit very painful and haphazard) manner:

One image that was very powerful for me was actually in a reading I did back in the 80’s which was a chapter from Alexander David-Neel’s book..um..*Magic and Mystery in Tibet*. I don’t know if you know about her, she was a traveler over a hundred years ago, she went to Tibet, and was an extraordinary adventurer, but she did encounter a lot of the practices, and one of the practices was..um..what’s it..Chöd, Chöd..[laughs]..and the way she contextualized it was kind of in an extreme manner, but it’s like taking on the suffering from all previous lifetimes to just be free of it all. Do I have any karmic debts to any of you beings out there, I summon you, let’s complete that..I mean that’s what I feel, you know, was sort of my life.

*A desire to contribute to others*. An important result of Byron’s experiences is his desire to contribute to others. Fortunately, he has managed to acquire a position with the mental healthy system in his state that allows him to feel relatively fulfilled in this regard:

*Byron*: I work today as a spiritual supports facilitator in mental health [laughs]. It’s very funny, I work for the state..um..I’m the only one who does this in [this state], and..um..I really respect all traditions, and I try to bring in those elements of spirituality that I think are vitally important for some people . . . In fact, I’ve worked in nursing in three state hospitals over a period of more than ten years and so I have this thing with the state hospitals [laughs], I’ve been an experiencer, and then I kept it quiet for years but now I’m totally out of the closet.

*Researcher*: It sounds like after your own experience, you felt really inspired to contribute to other people going through similar experiences, is that right?

*Byron*: Yeah. It’s my work, but I try to be of help and..uh..[laughs].

Byron has also become involved with peer support groups for people suffering from extreme states of consciousness:

I’m very involved with peer supports..so I do work with some really wonderful people and we have some really good alliances like that, people who understand, who get the ideas of recovery, which is not just some idea or something that you learn about, it’s something that you live, you know, and that’s what’s important.
**Trusting the process.** Through his own personal experience as well as his work within the mental health field, Byron has come to believe that it is important to trust in the innate transformative potential of psychosis, and he has a strong desire to spread this message.

*Byron:* [John Weir Perry] had no drugs at Diabasis house and the staff was instructed to allow people to go through their experience no matter how bizarre it was, ‘cause there was kind of a certain element of safety, you know..that’s what I needed.

*Researcher:* So, kind of trusting the process and sort of the innate wisdom that the process will eventually resolve?

*Byron:* That’s right. That’s right. That’s the shamanic journey that’s been in every culture except this one [laughs]. It’s important for people to understand that there are very deep spiritual experiences, and these are instances of these deep spiritual experiences that have transformative potential. Few, so few see that, and I think it’s very sad, and I...that’s my main heart thing is now. I’d love to find the way to sort of turn more people on to that [laughs]...it’s the real thing, you know, but others have tried, you know, like...uh...John Weir Perry and others, you know...um...there are some other...some of this stuff is coming out in different ways, but...uh...like that quote...uh...maybe R.D. Laing wrote it, I’m not exactly sure, “In the same waters that the mystic’s swimming in, the mad man’s drowning in.”... How to swim, that’s the main thing.

**Everybody’s in recovery.** Byron defines himself as fully recovered in that he “function[s] reasonably well in contemporary culture,” and, of course, he satisfies the criteria for this study. However, he adamantly considers his recovery an “ongoing journey”: “I’m a work in process... an unfinished being.” He takes this belief a step further and considers that we are all, in a sense, in recovery:

Everyone has different constructs of the nature of reality and self, and tries to be comfortable with them. Everybody’s crazy [laughs]...except for Buddha, a Buddha is a realized being. We all have that innate potential to attain that state, which is unbound wisdom and compassion. And we all, through our own delusions and preoccupations and negative emotions, we...we don’t see, we don’t have the insight to perceive these...the real reality.

**Seeing the harm of psychiatric treatment.** Byron has been working as a spiritual support facilitator in a state hospital for a number of years now, and based upon his
experience of the mental health care system from both sides of the locked door, he has come to believe strongly that our mainstream mental health care system does not work for many people suffering from psychosis:

You know, I do truly believe that..um..people experiencing extreme states of..uh..of uh..psychosis via schizophrenia or bipolar, some of them could really benefit getting in touch with those experiences and not just medicating them away . . . . I think the most important thing in the system itself which so very few recognize is the value of [these] experiences that, you know, they're not just delusions, you know. For many people, they're authentic spiritual experiences that can be worked with, but it takes a lot to do that, you know, it takes time and energy and money. I mean our system is set up to where it’s a business, you know, process people through. Drugs certainly won’t do it, and I think that a lot of people who are diagnosed in a sense lost their soul, per se, keep going through revolving doors, because they’re told that these experiences are pathologies, you know, they’re illnesses . . . . I think for many of us, it doesn’t work.

Seeing “spiritual problem” and psychosis as a false distinction. There is a strong contention within the field of transpersonal psychology that there is a valid distinction between spiritual emergency or spiritual problem and so-called genuine psychosis, where spiritual emergency is comprised of valid spiritual experiences and genuine psychosis is nothing more than a pathological mental illness. Byron’s own experiences with psychosis and his work with others suffering psychosis has convinced him that this is a false distinction:

Byron: I went to this..uh..spiritual emergency conference up in Hampton, Massachusetts in the mid 90’s and there were three editors for the DSM’s spiritual problem, and one was Lukoff, and one was..um..Lu, Doctor Lu who I never met, but the other one, but I can’t think of his name, a Western doctor, kind of..um..he was part of that conference, so they had a workshop [there] and he made that distinction, and you know, I really objected to it . . . . We’re all human beings, so we experience in different ways, you know, we have different brain functions or mind functions…It was a very intense experience for me and..um..I kind of argued with them [laughs].

Researcher: So, it sounds like you see a spiritual component regardless of how it manifests, whether someone has completely lost contact with consensus reality or whether they still have some bridge, some link there.

Byron: That’s right. All beings are sacred, all beings without exception.
Lasting benefits.

Finally happy to be here now. For many years after his recovery, Byron continued to find it challenging to find a real sense of joy and meaning in his life. However, in the last ten to twelve years, that has really changed:

I’m very happy to be here for the first time in all my life, because I never lost that kind of...longing for the ultimate get me out here kind of thing. That’s sort of behind my spiritual practice in a way, you know, how long do I have to be here...find rest [laughs]. But...um. I’m very happy to be here now. I have this incredible job, I’m doing my thing, and...uh...so...um. I’m very happy. I have grown kids and a granddaughter, so...and a beautiful wife, so the ordinary is my main practice now, and that’s beautiful. I, for the first time, appreciate the beauty that’s here in Samsara. The thing is with Samsara is like the whole thing is not about the thing itself, it’s our own relation, so it’s not going to some other place, it’s about being right here, wherever, and it’s your own perception of that.

Radical acceptance. Byron believes that one of the most important capacities he was able to cultivate during his journey of recovery is the capacity to accept all of his experiences, regardless of how painful or difficult they may be. This is a capacity he refers to as radical acceptance:

Radical acceptance is, I think, a good thing because whatever shows up, you know, it’s really good to be present with whatever shows up, and not to discard any of it...it’s your karma arising, and the thing is, ...you can’t change the karma but you can change the conditions, you can change your perception of how you work with this stuff.

Finding peace with groundlessness. A major theme found in Byron’s psychosis and recovery has been the experience of groundlessness and profound impermanence and a corresponding shift in his paradigmatic framework into one that is better able to accommodate these experiences: “The ground is not solid, but spacious. I’m coming to understand that ground is relative. There is no absolute independent ground anywhere. It doesn’t exist. Phenomena are impermanent and show up in uncertain ways.” Byron continues to experience the world in this way: “The rug gets pulled out from me quite
often indeed.” However, he has developed and continues to develop tools that allow him to maintain some bearing in this constantly changing world: “I’m still very much working with ground with my Tibetan practices.”

**Increased equanimity and resilience.** Over the past several years, Byron has been struggling with very serious physical health issues, and yet in spite of this, his wellbeing has continued to flourish, a result that he ascribes to his journey through psychosis and recovery:

*Byron:* I’m happier than I ever have been in my whole life, absolutely, even though I have severe illness. I had cancer of the throat, stage four cancer of the throat, and they don’t know why I’m here [laughs], and it was a spiritual journey for me as well with that, so now I have side effects from the treatments, and..uh..I can’t eat, and..uh..I got a stomach tube, and I guess I’m very susceptible to pneumonia. I was in the hospital four times with pneumonia last year, and so..death is very present with me...[but] I’m certain that I could keep on going for years [laughs].

**Increased connection with others.** Byron feels that his journey through psychosis and recovery has greatly increased his ability to connect with people:

I’m much better able to relate with people, which was a real deficit for me because…I really had not known how to socialize or..or the ordinary experience which was sort of baffling to me which other people engaged in regularly as I, you know, wasn’t very comfortable with it . . . . But that shifted, so I’m much more..um..I’m cultivating listening and being present with the other person’s experience, you know..um..to find a common ground or..what are you interested in, what are you interested in.

**Lasting harms.**

Overall, Byron feels that the lasting benefits of having gone through his psychotic process far outweigh the harms. When questioned, had some difficulty thinking of any lasting harms, but then he managed to come up with two.
A wounded healer. First, he says he can connect with a general sense of being a wounded healer: “the ideas of wounded healer, you know, is there,” although he did not elaborate on this further.

Regretting missed education. The second harm Byron mentioned was his regret at missing out on achieving a higher education, a result he ascribes to having gone through such intense spiritual experiences:

One regret I have is that I didn’t complete my education, you know, I wanted to be a doctor as a kid but I didn’t get there, you know, I did even make attempts subsequently, but these spiritual experiences were more compelling, so that didn’t work. But maybe if in another life, I would have been able to complete that… I’d be able to talk to more people, perhaps….I don’t have degrees per se, but um… I just have the experiences that I’ve lived….Anyway, I do regret not going to the… education, which I would have benefitted, I think, from some aspects of that.

The Case of Cheryl

Brief biographical sketch. Cheryl is a 33 year old Caucasian female. Approximately 8 years ago, at the age of 25, she experienced a psychotic episode that lasted about six to nine months total, with two months of it being what she describes as “extremely severe psychosis.” She was diagnosed with major depressive disorder, recurrent, moderate to severe with psychosis. She was hospitalized twice during this period and given Celexa (an antidepressant) and Seroquel (an atypical antipsychotic), which she continued to use at the smallest prescribable doses for about six months. According to the criteria used in this study, she considers herself as having fully recovered within a year or two after the onset of her psychosis, and having maintained her recovery for the six to seven years since. Prior to her psychosis, Cheryl worked in the mental health field for about two years in association with earning a Bachelor’s degree in mental health. She returned to the mental health field after her recovery, and has
remained there since, working under a variety of different roles with individuals diagnosed with severe mental disorders.

**Description of the anomalous experiences.** Cheryl’s most significant anomalous experiences during her psychosis were hearing voices and experiencing a number of unusual beliefs, most of which were closely associated with the voices.

**Contact with spirit guides.** With the intention of developing a set of skills that would help her to support others, Cheryl attended a spiritual counseling course. The course was designed to teach the students how to communicate with “positive spirits” and make psychic readings. The course went reasonably well; however, shortly after completion of it, Cheryl began to hear voices, which initially were quite benevolent and supportive:

> After the class, I started hearing these voices, they said they were my spirit guide, you know, they said they really cared about me, and I was like, this is great because I have no friends and I [laughs] broke up with my boyfriend and everyone hates me so at least, these things in my head, they like me, right? [laughs]

She felt a sense of “mild euphoria and liberation” at this point, combined with a sense of hope and the belief that “life was going to make sense again if only [she] listened to them and followed their guidance."

> After some time, however, the voices began to be quite directive with her: “. . . they started telling me all these weird things, you know, like, oh, you need to go here and do this, and if you go here you’ll meet your future husband, and you have to go rescue this person from here.” Cheryl initially followed these directions, which were relatively harmless at first, dealing primarily with trying to help her find her future husband.
However, it was not long before the directions became more unusual and others began to take notice:

They actually . . . told me that I needed to go to my job in the middle of the night where I worked with juvenile delinquents because I had to save the life of one of the students, and I did that, and [laughs] they thought I was like . . . I think they thought I was like a child stalker or something, you know, but . . . I think it eventually came out that I was just insane [laughs].

The voices continued to offer this unusual direction, but after repeatedly failing to provide any success for Cheryl, they took a decidedly malevolent turn:

. . . when it didn’t work out because it wasn’t real, that’s when these voices started to get really mean and say, well, you know, you’re a failure anyway, and we hate you, and God hates you, and you’re like worse than Hitler, and [laughs] you should go blow your brains out.

*The world’s most terrible person.* From this point forward, the voices continued to berate Cheryl with the most malicious language imaginable:

[The voices] told me all these things like God hates you, and I wasn’t even religious, but they said, you know, God hates you, you’re such a terrible person that even God who has never hated anyone before hates you now, he hates you so much that . . . he wants to send everyone to hell, like . . . now God hates everyone in the world because he hates me so much.

Cheryl soon found herself spiraling into an unbearably painful belief system that was in accord with the message of these voices:

So . . . the delusions turned into, you know, you’re the most horrible person and really this was the central thing was that I’m so terrible that everyone in the world is going to go to hell for ever and ever because of me.

As Cheryl’s belief system of her utter terribleness escalated, she experienced other closely associated unusual beliefs:

I thought people were going to kill me, I thought that this imaginary husband, that . . . somehow I had failed this imaginary husband and that he hated me now and he was gonna come kill me. Then, when I went to live with my family I thought that my dad was gonna kill me a couple times. I ran away once . . . because I
thought that my...my dad was gonna kill me, which [laughs]..my dad was never gonna kill me.

...and:

I thought that my life was like a reality show that only I didn’t know about, but in my a reality show, it was about how I was the most horrible person in the world and everyone was in on it but me, and...and the voices said that my recent ex-boyfriend that I had just broken up with was the star of the show, and he secretly hated me and found the idea that he cared about me disgusting and laughable, and meanwhile, you know, these voices told me that he had secretly been dating an earlier...girlfriend of his the whole time, then they told me that my family..um..were helping the two of them plan and prepare for their wedding and everyone was invited [laughs] but me.

Seeing time as an illusion. While Cheryl’s experience of utter terribleness (both in the messages of the voices and in her own escalating belief system) was the core of her psychosis, there were some other nonconsensus beliefs that emerged. In the early stages, while the voices were still benevolent, she went through a brief period where she believed that she “had been given this revolutionary theory”:

Cheryl: I thought that somehow I had in my mind that because time is an illusion, that somehow people that were all present in the world at the same time were all past lives of each other somehow...I just had this idea and I started thinking that I could figure out that, oh, this person is the past life of this person.
Researcher: I see, yeah, so different past lives of the same [person] might actually be sort of coexisting, like at the same time.
Cheryl: Yeah, that was my idea.

Terror and groundlessness. Cheryl also suffered from an overwhelming sense of terror and groundlessness during a significant period of her psychosis:

I would say I was in a constant state of extreme terror (and groundlessness) for at least two months. Some moments were worse than others. When I entered the crisis unit the first time I was wailing in terror, until a staff member threatened me that I had better stop it or else.

At one point, the terror became so ubiquitous within her experience that she felt as though she had lost all contact with anything else:
Another time I remember feeling completely “dead,” “not me,” “not human,” at one point, as if there was nothing left of me but terror and pain. I gave my brother a hug to try to “feel human” again. I think this helped a miniscule amount, although it probably scared my brother, as I know I was saying something to the effect of “Help! I’m not human! Help! I’m so scared!”

Confusing different realms of experience. Throughout the most intense stage of her psychosis, Cheryl found herself experiencing profound turmoil and confusion between the voices, her own beliefs, and what was happening within consensus reality; and she was desperate for any hope for relief, even if it had to come by suicide. She described one particularly poignant example of this:

The voices had been telling me to kill myself, but it was like I..I, you know, at that time, I really wanted to anyway, you know, so . . . it was kind of both. With the voices telling me that, you know, you’re so terrible and you need to do this, well you started to feel like, yes, I need to do this, so at that time it was my feeling, but also it was, you know, I had been hearing voices that said this, so . . . . It just kept getting worse and worse and then at one point I saw a bottle of pills and I was gonna take them but I was so out of it that I started to put my shoes on because I thought, okay, I’m gonna go to hell now, I need to put my shoes on, and then I was like [laughs].and then I realized, wait a minute, I don’t need to put my shoes on to go [laughs] to hell, and then I thought, no, I shouldn’t kill myself here in my house, my family will be crushed, I should, you know, do it later, and ultimately when I did try to kill myself, I went to the beach and tried to kill myself on the beach, but then I wandered back home when it didn’t work, thinking, oh, well maybe when I get home, maybe my dad will kill me then.

The onset and deepening of psychosis.

Childhood seeds of self hatred. In retrospect, Cheryl has come to believe that the painful belief system that became so dominant during her psychosis arose from earlier childhood experiences. She feels that she suffered from mild to severe depression for much of her childhood, adolescence, and early adulthood until the onset of her psychosis at age 25. She says her parents were not abusive, and, in fact, they played a significant role in her recovery. She does believe, however, that there were some significant
shortcomings in their parenting skills, which may have played a role in the development of a painful belief system that ultimately came to full force during her psychosis:

When I was little, I think they were a little immature to be parents and didn’t deal with their own emotions well and they would project them on me a lot, like..like I remember when I was four, my mom asked me if she was fat and I said yes. I didn’t even know what that meant, I just thought, well, my mom’s..well, she’s a lot bigger than me, you know. She got real..mad and stormed out and slammed the door, and my dad said to me, how could you do that, you know, that’s so terrible, you know . . . . When I was young, my mom was always yelling at me, we didn’t get along, and then my dad was always ignoring me, and . . . they loved me, they were never ever abusive to me, there was never anything like extremely traumatic...they had their own unresolved issues . . . they didn’t, you know, teach me how to love myself, and I never did. I never understood that . . . so even after I realized, wait I’m not in touch with reality, I didn’t love myself, I couldn’t forgive myself, I had no idea how to do those things . . . . All through my life, whenever I felt like I failed at something, I think I just . . . deep down I hated myself more ‘cause I didn’t understand..I didn’t have any coping skills.

Extreme isolation. Just before the onset of her psychosis, Cheryl went through a series of very stressful circumstances, most of which contributed to an increasing sense of isolation:

I was having a real hard time, because I had moved to be with my boyfriend but then we broke up like a week later, and then my friend moved away, like I didn’t know anyone, I wasn’t getting along with my roommates, I was unemployed, I finally got this job but it was this awful job with..um..juvenile delinquents, and they were all really mean to me, and it turned into this like traumatizing experience . . . . I had all these underneath. I think . . . lifelong depression and..and..and self-hatred was really like the source of [the psychosis], but then all these things happening at once brought it out, and then I think the spiritual counseling class kind of opened me up to the psychosis.

Connecting with benevolent spirit guides. Cheryl was on the verge of being overwhelmed by her tremendously isolating circumstances when she had the profound experience of connection with her “spirit guides” that resulted from the spiritual counseling course:

After the class, I started hearing these voices, they said they were my spirit guide, you know, they said they really cared about me, and I was like, this is great
because I have no friends and I [laughs] broke up with my boyfriend and everyone hates me so at least, these things in my head, they like me, right? [laughs]

Cheryl believes that this unusual yet profound experience of connection coming on top of her extreme experience of isolation opened the door to her psychosis:

I had all these underneath. I think . . . lifelong depression and . . . and self-hatred was really like the source of [the psychosis], but then all [of the isolating circumstances] happening at once brought it out, and then I think the spiritual counseling class kind of opened me up to the psychosis.

*Psychiatric system “not helpful at all.”* Cheryl managed to work through her psychosis with only two temporary hospitalizations in a crisis unit, and she felt that the support she received from the psychiatric system was not helpful: “I was seeing psychiatrists but they weren’t helpful at all.” When staying in the crisis unit, Cheryl was originally placed “on very heavy drugs,” but she developed severe side effects: “They made my heart feel very abnormal and I was scared I was going to have a heart attack. They also gave me visual trailers (i.e., totally slowed my brain down to where I would be looking at something but still be seeing the thing I’d looked at before that).” Frightened by these effects, she managed to find a way to reduce her intake of the drugs: “These things (esp. the heart issue) scared me so I started tonguing my meds (hiding them under my tongue to spit out later), a trick I had learned from my previous clients (when I was a [mental health] tech).” She found that one of the drugs seemed to reduce the voices, but ironically, this actually resulted in exacerbating her psychosis:

There was one medication that made the voices harder to hear (not sure what any of these were; they never told me) but I thought what the voices had to say was important (listening to them gave me some sense of control I guess) so I strained even harder to hear them, an effort which brought me further away from reality.
After leaving the crisis unit, she was maintained on small doses of two different psychiatric drugs—Celexa (an antidepressant) and Seroquel (an antipsychotic), which “was a compromise between what [she] wanted to do (take nothing) and what [her] family and doctors wanted (more drugs),” and she carefully weaned herself off of them about six months later.

Overall, Cheryl believes the use of these drugs were “mostly irrelevant” to her recovery:

There may have been a benefit I wasn’t conscious of (like healing from the extra sleep—I sure had been desperate for sleep!) I had a couple of health and weight problems that started around that time (which have since been solved) that I believe may have been related to the drugs, but I can’t prove it.

Hopelessness and suicidality. Throughout the most painful stages of her psychosis, Cheryl struggled tremendously with hopelessness and suicidality. The combination of the constant assault by the voices and her painful sense of terribleness and self-hatred were overwhelming. Shortly after her release from the crisis unit, she tried to kill herself using sleeping pills, was subsequently returned to the crisis unit, and she tried again to kill herself inside the unit, resorting in desperation to trying to cut her wrist with the underwire from her bra.

Recovery.

An exorcism. After several months of falling ever more deeply into despair and the certainty that the utter enormity of her own terribleness had doomed everyone in the world to the fate of everlasting hell, a surprising incident occurred that would be the first of a series of events that would set Cheryl on the path to recovery. After the failure of psychiatry to offer any real support for their daughter, Cheryl’s parents decided out of desperation to try taking Cheryl to an alternative healer—a practitioner of BodyTalk,
which Cheryl described as an integrative form of healing that attempts to balance the
various systems of our beings (energetic, psychological, physiological) by “prompting the
body energetically to heal itself”:

So, . . . the session with [the BodyTalk practitioner] didn’t really help, but she was
like, well I’m gonna go see my practitioner tomorrow at one, and I was like,
okay, whatever, I was still really psychotic and . . . I’m thinking to myself, we’re
all going to hell, so [laughs] you know, you do what you want but it won’t work.
So, the next day, all of a sudden I had the weirdest experience, and I had heard all
these voices constantly for like two months, and then all of a sudden these voices
inside me screamed, “No,” like an extended “NOOOOo000000,” and it seemed
like they were leaving and they didn’t want to, and all of a sudden it got really
quiet inside of me, and I looked at my watch, and it was like ten after one, and
right away, I got like really terrified because I . . . in my mind, I thought, well, these
screaming voices are parts of me that are leaving and they’re gonna go see my
healer and her healer and they’re gonna tell them what a . . . what a horrible person I
really am, and then my family’s gonna find out and they’re gonna be heartbroken,
and finally they are really gonna kill me so they can save [laughs] themselves
from me . . . I [had just been] starting to think that maybe they did love me and
now they’re gonna kill me ‘cause now they’re gonna figure it out [laughs] . . .
So, finally my BodyTalk practitioner called and she sounds like really . . . upset, and
I’m like, oh god, it’s true, and she said . . . you know, she said, “Cheryl, [my
practitioner] and I worked on you today and it was a very interesting experience,”
and she said it in like this really weird voice, and then she said . . . uh . . . “[My
practitioner] discovered that you had 64 negative attachments, and she removed
them for you. Um . . . she pulled them through herself and sent them to the light or
something, and she was like coughing and choking, and I’ve never seen anything
like it in my life,” and I was like, what, okay [laughs].

At first, Cheryl had some doubts regarding the effectiveness of this “exorcism”:

I didn’t really, you know, give this much thought at the time because it didn’t, you
know, immediately eliminate my delusions . . . I had this sort of sense up
until that point that it was like there were monsters inside of me . . . and then
when that happened, I was like, well maybe there were, but I didn’t really give it
much thought because I still thought, well I’m still the most horrible and evil
person, everybody still hates me, I’m still going to hell.

But then it soon became apparent that her experience of the voices had changed
significantly. The voices did return, but they were very different now:

[Prior to this experience,] there had been these really elaborate, extremely
elaborate abusive stories that just went on and on like 24 hours a day, where I was
like not even sleeping for [laughs]...for like a week, you know. And I remember at one point there was a word that one of the voices used, and I didn’t know what it was, and I looked it up in the dictionary and it was a real word, and...so it was like really real and really constant and really elaborate, and then after this happened, I was still hearing voices but they were like...kind of like less distinct from my own consciousness, maybe like my own brain. I kind of, and this is my theory, I don’t know, but I think it was kind of like all of a sudden it was so quiet that my own brain couldn’t stand it ‘cause it wasn’t used to it . . . . This was like a lot simpler, it was like voices that would say, die, die, die, and you know, like really simple stuff, whereas for a couple of months [prior to this], I was hearing these like really abusive stories, but these new voices were kind of like rehashing the old stuff, but just like really simplistically.

With this shift in the quality of the voices, they began to lose their hold on Cheryl and she began to take them less seriously. Cheryl now recognizes this as a very important turning point in her recovery.

**Recognizing her disconnect from consensus reality.** A second turning point happened not long afterwards with a different psychic healer. Cheryl’s ex-boyfriend arranged to have her visit a psychic who ironically practiced the same modality as that taught in the spiritual counseling course that had played such an important role in the onset of Cheryl’s psychosis. When Cheryl’s voices first began to turn malevolent, she had sought advice from the teacher of that course, but the teacher had only dismissed her experiences: “She said, ‘Oh, you...that’s a different thing, that has nothing to do with my class, you need to go take some medication.’” But this psychic took a completely different approach with Cheryl, validating her experiences but explaining that she was “like a child running out in heavy traffic and... getting squashed”:

[She said,] “you don’t really know what you’re doing and you’re getting all of these negative energies that are tricking you and manipulating you,” you know, and she told me, stop worrying that everyone’s gonna go to hell because of...of...um...the world has way too much love in it to be harmed by anything that I can think or say or do, and it was like all these other, you know, delusions and hallucinations have been proven wrong one by one, and...then it got to this point where this particular lady was challenging the essential...um...the essential
part of it, and she was coming at it from the angle that I guess I needed to come at it from.

These words had a profound impact on Cheryl:

So, I’m talking to her, and it was like, like everything that my family and friends and everyone had been telling me, and it seemed like it hadn’t made any dent at all, and then when she was telling me this, it like all coalesced at once, and I was like, oh my god [laughs], I’m mentally ill, and I was like totally stunned. I was like, I mean my jaw was probably open, I was like, wow [laughs]. um... you know, like I mean, I mean I can’t tell you how stunned I was. Everything all came together at once.

*Making sense of her madness.* The psychic’s words paved the way for Cheryl to make some sense out of the intense turmoil and confusion of the previous several months:

*Cheryl:* There was a gradual process where I was able to, as I got better, I was able to look back on what happened and make more sense of it than I did at the time that it originally happened but I think that... there were two things going on with me and one was that I was in... in touch with actual... um... you know, negative energies that were manipulating me... but also that I had psychological problems that were there either way, that I was like super, super depressed, and these two things matched up together...

*Researcher:* What I’m hearing is you had these sort of preexisting psychological issues from various challenges in your life but maybe they made you vulnerable to these negative energies--

*Cheryl:* Yeah.

*Researcher:* --and then once you were sort of exposed to those, then they just really went to town, distorting your own perceptions of everything, they really heavily distorted and manipulated [things], is that right?

*Cheryl:* Yeah. I would say that the psychological problems and these negative energies were really feeding off of each other... It’s like, they became... they were all a big glob of the same experience.

*Researcher:* Right. They really came together and really fed each other, and it led to this kind of vicious downward spiral into these... this really painful belief system that developed out of that.

*Cheryl:* Mm hmm. Yeah.

This new understanding and ability to make some sense of her madness in turn paved the way for a renewed sense of hope and determination to blaze a trail towards genuine recovery.
Standing up to the voices. Immediately after her discussion with the psychic, Cheryl took the first important step in her recovery. She made the determined effort to reclaim her power and stand up to the voices:

Cheryl: I thought, how am I gonna do this, you know, and so . . . I didn’t really entirely know, but I just took it step by step and the first thing I said was I sort of made this little announcement in my head like, okay, everybody out, you can talk all you want, I don’t care but I’m not listening to you, nothing you say is true, you know.

Researcher: So you really just closed the door. Right, you just decided..made a conscious decision that you’re just gonna ignore those voices.

Cheryl: Yeah. I made a conscious decision that I was gonna ignore everything. And, after that, you know, it was easier than I thought it would be, I guess because I hadn’t quite yet adjusted to the fact that it had already slowed down [due to both the earlier “exorcism” and now the lesson from the psychic], but then . . . . when I started to say, I’m not listening no matter what, that kind of helped them go down some more, and then the rest of my recovery was..um..worrying about loving myself and forgiving myself

A cat teaches lovability. At this point in Cheryl’s recovery, the voices had eased but she was still haunted with the stubborn core belief that she was simply not lovable.

Surprisingly, the most potent challenge to this painful core belief came from the family cat:

Everybody was trying to tell me that they loved me, that I was lovable, and it was like I wanted to believe them, but at first I still..I didn’t believe it, and I remember that it was like three a.m. one night and I couldn’t sleep and I was like, well, it seems..there are these real spirit guides that the psychic says that I have, these nice ones that she can talk to but I never talked to, you know . . . I said, well, if you’re really out there, if it’s really true that I’m lovable, can you give me some kind of sign. And . . . as soon as I said that, the family cat came into my bedroom and jumped on my bed and started rubbing up against me and purring, and I thought, huh, well she just loves me no matter what.

Practicing self-love and self-forgiveness. The experience with the cat began to crack the foundation of Cheryl’s painful core belief of being unlovable and her own self-hatred, but she realized that she still had a tremendous amount of work ahead of her: “I had this huge challenge of forgiving and loving myself . . . . Okay, the voices weren’t
real, I still, like I just tremendously hated myself.” She felt unsure how to proceed at this point, but fortunately, she soon came across the book, *Return to Love*, by Marianne Williamson. The teachings in this book offered her a shift in perspective and some tools that allowed her to begin the difficult work of learning how to forgive and love herself:

I came across the book in Barnes and Noble, and it just sort of leaped off the shelf . . . . I thought that because of what these voices were saying, and like I said, I wasn’t really religious before, but..but from what these voices were saying, I thought that God was gonna punish me, and then this book talked about God as being the essence of love, and it talked about, you know..it taught me that I was okay the way I was and I didn’t have to earn love, I didn’t have to be a certain someone or do a certain thing or accomplish something or whatever in order to be lovable, and I thought, you know, I used to think, well, I can’t be forgiven, there’s a line where you can’t forgive, and this book taught me, no, there isn’t, you know, you can forgive no matter what, and you just gotta start over and start loving yourself.

With some guidance and a renewed sense of hope, Cheryl became determined to start chipping away at her hatred and anger. She began to practice the intentional generation of love for herself and others, facing the continuing onslaught of hateful thoughts:

I decided that I would start visualizing love coming out of my heart and surrounding me and that gave me feelings of self love, so I kept trying to do that . . . . I kept reverting to the feeling, no, you deserve to die, I should kill myself, but I found that when I didn’t love myself, I didn’t love others, and I felt like these other people who were so nice to me, they really deserve it even if I don’t, and I kind of forced myself to love myself for the sake of my family . . . . So I just kept practicing this, you know, I kept like being, god, I’m the worst person ever and ever, but no, no, no, but then I would start to feel like, grrrr, everyone is awful, I hate everyone, the world is bad, but then I thought, no, no, no, I have to be loving towards them, I have to start by loving myself, okay, I love myself, I love myself.

Along with this renewed effort to develop love for herself and others came an effort to develop forgiveness for herself and address the deep core experience of herself as an utterly terrible and unlovable and unforgivable person.
The importance of love from her family. For much of her psychosis, Cheryl was unable to believe that anyone could really love her. However, she realizes now that her family’s persistent love and care for her eventually broke through her belief system and played a crucial role in her recovery:

My family, everyone kept trying to tell me that they really did love me and, you know, and it kind of seemed pretty obvious meanwhile, but... the voices said, oh, well they think they love you but their higher selves don’t love you... but meanwhile, you know, I was starting to think, you know, when I tried to kill myself and they were sobbing, and then when I lived and they were so ecstatic, I’m like, huh, well maybe [laughs]... maybe that’s not true that nobody loves me.

Having come across a message of hope. Cheryl had studied psychology in college and worked in the mental health field prior to her psychosis. She said that, like most people in the mental health field, she was exposed to the myth that once someone is diagnosed with a severe psychotic disorder, full recovery is not possible and they must remain on debilitating medications for the rest of their lives. Cheryl is extremely grateful that, during her undergraduate studies, she came across the research by the World Health Organization (Hopper et al., 2007), Mosher (1999), and others who validated the possibility of full recovery from schizophrenia and other long-term psychotic disorders. She credits this knowledge for providing her with some spark of hope for her own recovery, even in the darkest times:

Cheryl: When I got to this point where I got sick... as soon as I realized, oh, I’m like not well, I’m having a mental illness type of experience, like I remembered, okay, but I can get better because... these other people have gotten better... but I didn’t know how and there was no professionals who were telling me how. I mean, the professionals that I worked with were like so unbelievably maddeningly clueless [laughs]... but um... but I thought, well, I’m gonna have to figure it out, and I guess it’s just.. my main belief is that, you know, here we don’t believe that the people can get better and so they don’t, and I feel that in addition to love and.. loving myself and other people loving me and figuring everything out, the most important thing was that I had the idea that maybe I could get better.

Researcher: So it sounds like you’re talking about hope, huh?
Cheryl: Yeah. Whereas if I hadn’t had that prior knowledge that maybe I could get better, I feel like maybe I really would have finally succeeded in killing myself because it was like I thought, well, I just can’t keep living and staying this..this sick . . . I was seeing psychiatrists but they weren’t helpful at all, and all I did was I followed my inner guidance and I sort of followed my, you know, spiritual guidance and whatever as to...step by step, how do I get better . . . . I just feel so grateful that I..had known about..I had had that message of hope, because that, and along with love, hope and love really are the two things that saved me.

**Lasting personal paradigm shifts.**

**A deeper experience of interconnectedness.** Prior to her psychosis, Cheryl had taken an intellectual interest in the concept of interconnectedness, but after recovering from her psychosis, she realizes that she has experienced this on a much more profound level, and that this experience has allowed her to experience much more benevolence in the world than previously:

I, you know, had studied modern physics, and I was like, oh yes, the world is all connected, it’s all beautiful, and that’s what I thought intellectually, but I guess..I didn’t realize it, but deep down, emotionally, I didn’t really believe all those good things, and with this experience, I was like, oh, now I really see how the world is all connected, and I feel all the compassion and how the world is like so much nicer than I thought and not this thing that feels out to get me.

**The world is not so black and white.** Cheryl finds that she now experiences the world as “not so black and white anymore.” Rather than seeing inherent “evil” in the actions of others, she sees that they are “wounded or ignorant in some way.”

**A broader range of positive emotions.** Cheryl finds that she now experiences a wider range of feelings, particularly more joy, less anger, and an increase in feelings directly related to a sense of connection with others:

I would say that I do experience a broader range of emotions -- particularly I feel a broader range of *positive* [Cheryl’s script] emotions: overall very positive feelings about the world and everything in it. I also feel more sadness for the suffering of others, because I am more empathetic; I recognize others pain more easily and love
others more. In contrast, I feel a lot less anger; the psychosis healed me of a lot of unresolved anger issues.

An increased desire to contribute to others. Since her recovery, Cheryl has discovered an increased desire to contribute to others who are struggling with extreme states of consciousness: “I want to go to graduate school, and you know, get to a position...I want to keep learning and into a position where I can better..um..better reach people and better help people and bring that message of hope to others so they can have it like I did.”

A newfound wisdom to support others in extreme states. Prior to her own bout with psychosis, Cheryl had wanted a deeper understanding of psychosis and recovery so that she could help her clients. Ironically, she now finds herself with a deeper understanding than she had ever asked for:

It had been my dream before this had all happened that I would find out more about psychosis and recovery from psychosis, and I hadn’t ever specifically thought to myself, boy, I wish I was crazy [laughs] so I could help my clients, but then ultimately that’s what happened.

Now, she continues to work in the mental health field and finds that her own experiences offer a number of useful insights into working with her clients.

Recognizing the interplay of different realms in psychosis. One insight mentioned earlier is her belief that many people experiencing psychosis may be struggling with the mixing and confusing of several different realms of experience:

You could say that it was mental illness, you could say that I was possessed, I kind of think that it was both, and I kind of think that maybe a lot of people have both...I think that...there were two things going on with me and one was that I was in...in touch with actual..um..you know, negative energies that were manipulating me..and..and..and, but also that I had psychological problems.
Recognizing that her psychosis led to healing at a profound level. Another insight Cheryl has acquired is the recognition that her psychosis provided her with the means to heal at a profoundly deep level:

[Prior to the psychosis,] I didn’t really recognize that I was worse off mentally than other people, and to the extent that I did, I had no idea what to do about it. I did read some psychology books but they never . . . they would help me on a very superficial level, but this psychotic experience really just like ripped, I guess you would say, like ripped off all the layers and got right to the core [laughs]..um..and..and then, you know, when I was able to look at my core of self hatred and heal that, then I just..I built my mental health on that from here.

Seeing antipsychotics as more of a hindrance than a benefit. Based upon her experiences from both sides of the locked door, Cheryl has come to believe that the treatment for psychosis prevalent within the mainstream mental health field has some serious fundamental problems. She believes that one serious problem is the heavy use of psychiatric drugs as the primary treatment:

I don’t believe that mental illnesses are caused by chemical imbalances, or that psych drugs have any (honest) science behind them. So my general worldview is that anti-psychotics are more of a hindrance than a benefit to people in general because they are a distraction from the real problems and the real solutions; they are like disconnecting the warning light on your car and saying it is fixed.

Recognizing the harm of the message of hopelessness. Cheryl has also come to appreciate how very important the message of hope is in recovery from psychosis, and how so very detrimental is the message of hopelessness that is so prevalent within the mainstream mental health field in the West. As mentioned above, she recognizes the hope for genuine recovery as among the most important factors in her own recovery and also the factor which may very well have saved her life. As she has integrated her own personal experience in this regard with her own work within the mental health field, she has come to realize just how important it is to spread this message:
So many people are telling [those diagnosed with a psychotic disorder], you can’t get better, you’re just gonna be sick for the rest of your life and you’re gonna have to take medication for the rest of your life, and they believe it because they don’t..they don’t know any better, and it’s like so sad, and I just feel so grateful that I had known about..I had had that message of hope, because .. hope and love really are the two things that saved me . . . I just wanted to say that because I think it’s so important and, you know, I think that’s why other people were not..we don’t see recovery as much because people don’t believe in it.

**Lasting benefits.**

*A greatly improved sense of wellbeing.* Cheryl expressed that her wellbeing now is much better than it was prior to her psychosis:

> I would say that [my wellbeing is] . . . way, way, way, way, way, way, way better . . . . Things are better now, because many of the lessons I learned in the process of figuring out how to recover from severe mental illness were lessons I needed to learn anyway to help me on the much smaller scale of daily life . . . . I never had any tools of how to love and forgive myself . . . . I gradually figured out, oh, this is how you love yourself, this is how you forgive yourself, and . . . I didn’t know how to do that [before] . . . . I have a much better handle on my own mental health in general, and I feel that having conquered my severe psychosis, I can conquer anything. Recovering from the illness was a transformative experience rather than a return to my previous level of health.

*A more secure sense of self worth.* Throughout Cheryl’s journey through psychosis and recovery, she underwent some profound changes in her sense of self-worth and self-importance. Prior to the psychosis, she describes her sense of self-worth as relying upon an insecure foundation, being based primarily on accomplishments and traits that require perpetual propping up (such as intelligence). As her psychosis unfolded, this insecure self-worth and self-importance underwent a profound reversal and expansion, going through “positive” and “negative” phases as it did so:

> During the psychosis I went through an early phase where my sense of self-importance was based on seemingly positive things (i.e., the voices giving me a seemingly revolutionary theory) and then of course there was the much longer negative phase of believing everyone would go to hell because of me.
As she recovered from these experiences, her experience of self-worth came to rest on a foundation that is much more secure and evenly balanced: “As I healed, I began to realize that I am important just for being me—the important part being that I am no more or less important than anyone else. I realized I did not have to do or be anything in particular to be important or loveable.”

**Increased resilience.** Cheryl said she often hears others assume that, because of her history, she must have serious ongoing mental health issues; however, she expressed that, to the contrary, she feels much more resilient and able to take care of herself:

People always assume, oh, well, you know, my mental health must be really bad [laughs] because I had this experience, but it’s actually really good because all that learning that I did in the recovery about, you know, . . . how to get out of my really extremely deep psychotic depression that I was in, that now maintaining it is kind of a piece of cake in comparison.

She also addressed the common assumption by others that after going through her psychotic breakdown, she must be more susceptible to experiencing another one:

There are times when I get really anxious and distressed but . . . people don’t understand because of society’s view of mental illness, they say well what if you have to go back to the crisis unit, and I say, really, you know, it’s not like I feel it’s my job to convince them, but it’s like they just don’t get it. I really am. . . I have so many more tools now. . . I know how to take care of myself, and I make a point to take care of myself, to love myself, to take a break when I need it, you know.

**A greater sense of connection with both self and others.** Cheryl believes that, in general, her sense of connection with others has increased greatly since prior to her psychosis. She believes that the development of her love for herself and appreciation of the love of others has played a significant role in this regard:

I think, you know, before when I had all these seeds of self hatred, I probably had seeds of other hatred, I mean I was. . . I was probably judgmental, I don’t think I really quite understood people, I mean I wasn’t like a terrible person, but I guess looking back on it, I wasn’t really the nicest person in the world, and not that I am now, but I feel like now that I love myself, I have so much love for others and so
much compassion . . . . When I encounter other people, either clients or..um..sometimes my husband has a general anxiety disorder and sometimes he has occasional psychotic episodes, and I just remind myself, you know what, you were there and, you know, other people loved you, and..and..and that helped me to love others . . . . I also just feel like I have a much deeper connection with people than I did before, whereas before, it was more..uh..superficial, and now I guess I’m more connected to my own heart, and that enables me to..better connect with other people.

**Lasting harms: Residual trauma from the intensity of the psychosis.** Overall Cheryl finds that the benefits of having gone through her psychotic process far outweigh the harms: “Any ‘harms’ pale very much in comparison to the benefits.” However, she considers her psychosis a “traumatic experience,” and she does find that she is occasionally vulnerable to being “upset (triggered) when something reminds [her] of it.”

One example of this is in her relationship with her husband, who currently struggles with occasional “brief psychotic episodes” and associated anxiety. Cheryl has noticed that, during those times when her husband is going through his own inner turmoil, she sometimes experiences a sympathetic response and feels faint vestiges of the profound terror and groundlessness that pervaded her most intense period of psychosis:

> My husband has mental illness, and he sometimes has brief psychotic episodes, so although I love him and am happy in my marriage, sometimes his mental health affects mine . . . . At those times, I have free-floating anxiety, panic and a fear that “maybe I’m bad.” This terror can be bad at times but nothing compared to what I [experienced within the psychosis]. It does seem related to some of the issues that caused my psychotic experience, but triggered by my husband’s anxieties.

**The Case of Jeremy**

**Biographical sketch.** Jeremy is a 36 year old Caucasian male raised in New England and currently living on the West Coast of the United States with a wife and a two year old daughter. At the age of 21, he developed a powerful nonconsensus belief system that continued to dominate his consciousness for about half a year and then
gradually faded away over the next several years. Initially, just several days after the onset of his psychosis, he was hospitalized for ten days and diagnosed with *psychotic disorder NOS (not otherwise specified)*. He was given a heavy dose of Risperdal (an atypical antipsychotic) while hospitalized, remained on a moderate dose for about three months afterwards, and has remained free of all psychiatric medications for the fifteen years since. According to the definitions used in this study, Jeremy considers himself as having been fully recovered for over fourteen years. He has been working as a licensed psychotherapist for over ten years, specializing in working with people suffering from psychosis and other extreme states of consciousness and devoting a significant amount of his time to the psychiatric survivors movement.

**Description of the anomalous experiences and the onset and deepening of the psychosis.** Jeremy’s psychosis consisted primarily of one nonconsensus belief system that “had a firm grip on [him]” for about half a year, after which he “continued to experience ‘blips’ it” for several more years. This system included beliefs of messianic power and persecution and feelings ranging from profound liberation to overwhelming terror, all of which revolved around a core theme of good versus evil forces. Jeremy’s psychosis has a strikingly coherent narrative, so in an effort to minimize disrupting this coherence, I have combined the themes relevant to the *description of the anomalous experiences* with the themes relevant to the *onset and deepening of the psychosis*. The themes for the *description of the anomalous experiences* are as follows: annihilation anxiety, flipping from annihilation anxiety to enlightenment, enmeshed with his mother’s psychosis, belief in the “white” and “black” orders, joining a group of messiahs, and persecuted by the black order.
Although Jeremy’s psychosis came on quite suddenly, over the course of just one evening, he later came to recognize that a number of factors that began much earlier all culminated synchronistically that evening to create what he calls “the perfect storm.”

**Childhood shame.** Jeremy feels that one of the most significant contributing factors was having had a number of highly shameful experiences throughout his childhood:

My mom was kind of...um..pretty verbally abusive to me growing up, and...um...you know, my dad kind of an emotionally distant person, and...um...I think that what happened was that I had a lot of trauma from that...things that were unresolved about that...I should also add that I was bullied in junior high school terribly, like really, really bad. I ate alone in the cafeteria in seventh grade. I mean, . . . anybody . . . who’s had to eat alone in the cafeteria in seventh grade . . . can imagine the kind of...you know, the kind of shame that that...um...that brings up.

**Shedding his identity and losing his community.** Similar to most young people in our society, as Jeremy reached late adolescence, he had to begin the process of individuating from his family and seeking a meaningful life for himself. By this point, he had established an identity as a well-respected skateboarder with a sense of connection with that community and the promise of becoming professional; yet he found himself beginning to have strong intellectual yearnings:

I pretty much probably could have went professional if I had not gone to college and moved out to California and really applied myself. I was probably one of the, you know, sort of top skaters in the Northeast . . . Well, then I discovered that I really liked thinking. I liked ideas. I liked philosophy.

Being torn between his love for skating and his intellectual aspirations, he found himself at a crucial choice point, and in the end, he chose to let go of his skateboarding dreams and go to college: “that’s when I sort of started becoming interested in psychoanalysis, in philosophy, and then I decided I was gonna devote myself to being an
intellectual.” This choice, however, had a profound impact on his sense of security and belonging, and it ultimately became a very significant factor in the onset of his psychosis:

So, when I went to college, it was a big decision point to either, you know, go be a professional skateboarder or..drop that. And so I chose to go to college, and I experienced a very..very intense..you know, my identity..skateboarding, I don’t know if you know much about skateboarding, but, when you’re like a skater..everything revolves around skating. You read the magazines, you..that’s all you do 24 hours a day is think about skateboarding . . . . So, when I got to college, I didn’t have that community, I didn’t have that identity, and that was the first kind of like..I would say that’s really the first movement of this episode that culminated on that night, because I..I was depressed. You know, I wasn’t like clinically depressed, but I was like definitely like..I mean I would go to class and do all the stuff, but I was like totally isolated and..and I just..I was experiencing a lot of anguish, and I had enough insight to know that it was because I had given up skateboarding, and I didn’t have anything.

Disillusionment. In spite of his difficulties with transitioning from skateboarding to the academic life, Jeremy soon found himself thoroughly enjoying the study of psychoanalysis. An opportunity soon opened up for him to move to London and continue his studies at the Anna Freud Centre, and he jumped on it. Shortly after beginning his studies there, however, he experienced a profound disillusionment:

I idealized analysts, and then when I got to the Anna Freud Center, I think my idealization of them crashed into some kind of..really..ugly reality where they were all sort of very petty and political, and the Kleinians were squabbling with the Anna Freudians, and the..you know, and it was just like..I was like, wow, these are supposed to be some of the most thoughtful, enlightened people in our culture who look at themselves, and yet here they are behaving like high school..junior high kids.

Jeremy’s disillusionment regarding the maturity and wisdom of the psychoanalysts soon expanded to include the entire human race in general:

I realized that adults did not really know what they were doing. They were trying very hard on the best information that they had, but there was really nobody kind of like in control. There was no kind of like wise group of people steering us, and I found that to be terrifying . . . . While it was terrifying `cause it was like, wow, you mean this whole..this round ball floating in the universe is just kind of like
spinning and people are just kinda like ramming into each other, and it’s all one big hurly burly.

**Heroic strivings.** After Jeremy’s profound disillusionment with the human race, rather than succumbing to fear and/or despair, he was able to see this insight as an opportunity to make a significant contribution:

As much as that realization was terrifying, it also was liberating because it was like, wow, you know, maybe I can...I have a voice here. I can...I can make a contribution. I can do something. I can come up with something that...might help humanity. . . . I started reading a ton of stuff. . . . I guess I had the realization, I was like, wow, I can like..like I want to make a contribution to the world of ideas and thought, you know.

So, he took the self-discipline and confident independence that he had cultivated in his skateboarding and directed it towards this new goal:

*Jeremy:* I kind of said, fuck college...I mean I still went to my classes, but I was just like, well, the hell with institutionalized learning. I’m gonna learn...you know, it was like the skate...it was like the punk-rock DIY [do it yourself] skateboarding thing of like, do it yourself, man, like learn...just do it, you don’t need anybody, you know, so I started reading everything.

*Researcher:* Carved your own path.

*Jeremy:* Exactly.

Jeremy now realizes that this sense of heroic striving, and particularly the striving to be a peacekeeping hero, began much earlier in his life. He realizes that, in many ways, he was trained to take on that role within his family:

My whole role in my family was to be compassionate [laughs]. I mean I was trained to be a therapist from age zero, I mean... to care, and be in other people’s minds, and you know, be trying to read other people’s intentions are. As young as sixteen, I was already...I remember, yeah, my stepmother saying, what do you want to do, Jeremy, and...I said something like, oh, I want to make a major contribution to world peace, you know [laughs]. She was like, holy...okay.

**Becoming aware of self esteem battles.** As the realization of living in a world without a group of truly wise leaders began to take hold and blossom, and as he began to
study this phenomenon more intensely, Jeremy became particularly inspired with Noam Chomsky’s work: “I thought, I want to be like Chomsky . . . . I want to think very deeply about the human condition and come up with some kind of response that helps..helps poor..us poor humans down here on this earth, and I really held him up as a model, somebody who was fighting that fight.” Jeremy began to pay more attention to the behavior and interactions of those around him: First, he began to notice “that people would make other people feel bad a lot of times.” As he paid more attention, he came to the realization that this behavior was actually extremely pervasive, even amongst the psychoanalysts. He soon formulated a theory that he believed explained what he was observing:

I sort of had developed my own theory about how the world was running, and it was based on how people..basically, how people went around constantly scooping up self esteem from everybody else by putting them down subtly all the time. So when I was at the Anna Freud Center, that’s..that’s what I saw happening . . . . That’s what I was zeroing in on. I thought these people would be evolved, getting little self esteem nibbles, let’s call them that, from their colleagues. And yet, they were..it was even worse, ‘cause they were just doing it in an extremely sophisticated language. And that’s what really..that’s what really blew my mind, was that.

Jeremy felt that he had stumbled onto something really big, perhaps just the insight he needed to contribute to the peace of the world in the profound way for which he really yearned. It would turn out that the combination of this powerful insight and his heroic yearnings would be another important factor in the eventual onset of his psychosis. This belief system is not particularly bizarre and most likely has some significant validity within consensus reality; therefore, it would most likely not classify as an anomalous experience. However, Jeremy does feel that he “blew it way out of proportion thus instigating a kind of proto-paranoia.”
Liberation from isolation. During this period of deep contemplation of the human condition, Jeremy not only observed the behavior of others, but he also turned his attention inwards and became painfully aware of the battle going on within himself, especially with regards to his social anxiety and associated isolation from others. This penetrating awareness resulted in a profound sense of inner peace:

I really got into Karen Horney, I think maybe 'cause she wrote about self analysis. That interested me and I was doing a lot of that, and I realized I was a very anxious guy, like I had a lot of social anxiety . . . . There was a big epiphany, actually . . . . I remember it clear as day. I was in this café . . . [with] my friends . . . and all of the sudden, it dawned on me that I was..it was as if I had been in a warzone, and I had come out of the warzone, but I was still fighting a battle inside of me, and I was like..and then I realized, I’m like, what battle am I fighting, and why..why am I still fighting it within myself if it doesn’t exist anymore. And once I had that thought, I experienced this incredible sense of calm and wellbeing at that café, ‘cause I was like, I don’t need to be afraid [laughs], you know, yeah . . . . I [let] go of a lot of anxieties that I had and I started to feel these intense feelings of liberation, like, wow, I don’t have to be anxious in a social circle, or maybe everybody else is just as anxious as me, you know, letting all that go, and it was just really liberating.

This moment became an important turning point in Jeremy’s journey towards psychosis. Armed with these powerful insights into the human condition and a renewed sense of liberation and connection with others, Jeremy felt he was well on his way towards making a serious contribution to the human race.

From liberation to profound shame. Jeremy returned home for the Christmas holidays soon after his experience of liberation. However, as enjoyable as these feelings were, they continued to strengthen and eventually threatened to become overwhelming:

When I got back home from London, I had kind of severe jet lag and I kept having these kind of breakthrough experiences, and I remember on the eve of Christmas, I sat up with my mom and we had this really deep discussion and we ended up like crying together and hugging, and it was really powerful, but what happened was that I couldn’t stop my mind from having these insights, and I became..I just wasn’t able to sleep, and I wasn’t able to turn it off.
In this highly elated yet vulnerable state, Jeremy then did what he later recognized was a “very silly thing”:

I went over to a friend’s house and..uh..smoked some pot, and that basically sent me through the roof. I..I have never experienced..I had a hard time being in my body. The feelings of joy and elation were so intense they were almost painful, and as that was going on..um..this guy came over and..uh..he wanted to form a band with me. I was playing drums at the time, and I got really into that idea, and..he found out that I actually had to go back to school, and so he said, no, no, no, let’s not do that. And I just thought it was such a great idea that I kept kind of like pushing the issue, and to everybody there who was witnessing the conversation, they were probably like, you know, Jeremy, like stop, you know, he said no, but I was like, no, no, no, let’s just do this, let’s just do it for like a couple weeks, we can make some cool songs. And then one of them..one of my friends who was there who now I realize is basically verbally abusive, he had issues with that, he..he..he jumped in the conversation and really shamed me..um..in front of a lot of people. And that proved to be the straw that broke the camel’s back.

**Annihilation anxiety.** That evening, in a very brief period of time, Jeremy had plummeted from a state of extreme elation to extreme shame, and the result was completely overwhelming:

I experienced almost like an existential void open up and I fell through and it was like all these feelings of terror and panic flooded in, and I was so overwhelmed by those feelings, I did not know how to handle them . . . . Psychoanalysts talk about annihilation anxiety, and..uh..I think that’s pretty accurate to what..what I was feeling . . . . I was completely terrified. There was like..there was no ground..there was no ground..I don’t know, it’s hard to like..there was no floor to my experience.

**Flipping from terror to enlightenment.** After struggling for some time to maintain his sanity in the face of such overwhelming “annihilation anxiety,” Jeremy experienced a sudden and profound shift from terror to grandiosity. In retrospect, he believes that in order to compensate for such extreme terror, his psyche was forced into extreme compensation: “I think what happened was, due to the terror, my..I became extremely grandiose, and I thought, well, you know, the flipside of that terror is I’m enlightened. I must be enlightened.”
**Enmeshed with his mother’s psychosis.** Initially, after being overwhelmed by the shaming incident, Jeremy “desperately called a whole bunch of friends” in search of support, but he was not able to connect with any of them. So, he returned to his home and to his mother who also happened to be struggling with some nonconsensus experiences herself. Jeremy has come to believe that it was his subsequent interaction with his mother while in such a profoundly vulnerable state that “truly kicked [him] over into the psychotic realm”:

Something happened between my mom and I where I told her I was becoming enlightened. I don’t know how I even got to that point..um..and my mom is partly psychotic. She..um..she believes all sorts of magical things, and so . . . she said, oh great, you’re becoming enlightened, well, why don’t you tell me if my friend is secretly plotting against me . . . . That was the absolute tipping point, ‘cause then it was like, oh my god, I am really..my mom believes I have special powers and that, you know, . . . and then I just..I went on a whole rant about how her friend was in fact spying on her and there was this whole conspiracy against her.

So Jeremy found himself becoming enmeshed in his own mother’s nonconsensus belief system. As they discussed the supposed plotting of his mother’s friend, Jeremy somehow came to believe that his mother’s boyfriend was also in on the “plotting,” which in turn escalated into the belief that there must be a “black order,” and that his mother’s boyfriend must be involved with it.

**The “white” and “black” orders.** During the folie à deux experience between Jeremy and his mother that evening, an entire nonconsensus belief system unfolded within Jeremy’s mind in surprisingly short order:

Somehow I got to thinking that [my mother’s boyfriend was a member of the black order].I mean it’s all very sort of oedipal. So . . . for some reason, it became clear….that the world was controlled by..um..these very evil people who were very, very smart and actually had it all figured out and were actively manipulating the world for their ends…and… I realized I had [laughs].I put it together that . . . the mind control weapon that they were using was making people go around, you know,… nipping at each other [laughs], essentially, [battling for self esteem]. So
they had us all fighting, yeah, yeah . . . . [I also realized] they were persecuting my family, they were persecuting my mom . . . . [And] this guy, the boyfriend, he was . . . he was sort of but like a minor functionary in the hierarchy of the black order, but like nonetheless, he was part of it . . . . and that there was also this good force. There was like this . . . they appeared to me as kind of like a white . . . like white beings . . . and they were kind of like angels, so to speak. They were the people who were also very wise and very smart and compassionate, but who were working to fight the evil people. And, you know, in my . . . in my thinking, I thought people like Noam Chomsky were part of this . . . this white force . . . um . . . and other assorted kind of public figures who, you know, who had shown that kind of intelligence and compassion.

**Joining a group of messiahs.** As mentioned above, Jeremy had a powerful desire to contribute to humanity long before his psychosis. So, after the nonconsensus belief system regarding the white and black orders came to dominate his consciousness, it is not particularly surprising that this heroic striving escalated to the level of messianic striving:

[Immediately after coming to the realization of the existence of the white and black orders,] I started thinking that I was becoming on that team. I had finally broken through to the realization that that was my future, to be on this force of people and to find them and ally with them, but that the evil people now knew because they were psychic. They knew that somebody had broken through and found them out, and found out their secret plan, and now they were gonna come and get me, and so paranoia set in.

**The perfect storm.** While Jeremy’s nonconsensus belief system apparently formed in a surprisingly short period of time (essentially within a few hours), he has come to recognize that all of the earlier pieces mentioned above had provided all of the essential components, and that the “magic mix of circumstances” that took place that evening created the ideal set of conditions for the brewing of “the perfect storm”: “It’s amazing, looking back, how perfect everything felt . . . it’s so incredible.”

**Persecuted by the black order.** As the paranoia set in that evening, it suddenly occurred to Jeremy that the black order was going to attack his brother, who was living at his grandmother’s house several hours away at the time: “Now I was hunted, now I was
persecuted, an..um..then I thought they were gonna attack my brother. Oh, well, then I was convinced actually that my brother had already been under attack for quite some time, and we had to go rescue him.” Surprisingly, Jeremy was able to convince both his mother and thirteen year old sister of this. So, now in what Jeremy describes as a “folie à trois,” the three of them all hopped in the car and headed to his grandmother’s house. It turns out his brother was not there, and after looking all night for him, they were unable to find him. This greatly exacerbated Jeremy’s paranoia, and by the following morning, he found himself overwhelmed by his paranoid thoughts of persecution and feelings of terror. He began “to say things that were kind of frightening…to [his] family” and slept very little, if at all, for a couple more days.

An island of clarity. At this point, now several days into his psychosis, Jeremy experienced a temporary “island of clarity” and realized that perhaps he could gain some clarity into his situation if he could manage to get some sleep: “I think I was like, okay, something..something’s not right. I think I just need to get to sleep. I think I had a moment of clarity . . . . I think I had one of these islands where my ego kind of recrystallized slightly [laughs].”

“Broken” by the psychiatric system. Upon having this moment of clarity, Jeremy asked his mother to take him to the hospital so he could get some medication to help him sleep. Once inside the hospital, however, he was not allowed to leave until ten days later:

I could not get to sleep and that really started scaring me. So I said to my family, I said, okay, I should go to the hospital to get some sleep. So, when I got to the hospital, my family had been..had started telling the psychiatrist things I’d been saying and they started to ask me questions about the things I’d been saying, and..and then I knew that..um..I was caught, so to speak, like the evil forces had actually succeeded in getting me. And so..um..I initially went there just complaining of trying..I wanted to get some medicine to help me go to sleep, but, you know, I spent ten days on the inpatient unit.
The combination of the lack of genuine care, the heavy use of antipsychotics, and an experience of isolation while in the hospital had a particularly devastating effect on him:

I was on a very high dose of Risperdal, which is an antipsychotic medication. It made me drool horribly...um...I looked like a zombie. My friends who came to visit me at that time were just like, wow, where did Jeremy go, and...um...the inpatient unit was just terrible. Nobody talked to me...um...I was pretty much ignored. I was very frightened, very scared...When I emerged from the inpatient unit fourteen days later, I was a shell of a human being.

After leaving the hospital, Jeremy spent several weeks in their outpatient program: “That was basically another kind of joke. Um...the staff treated us like we were little children and needed to like manage our stress and learn how like basic living skills. It was very demeaning.” In the end, he emerged from this treatment feeling “totally and utterly broken, empty”: “Talk about surviving, I mean that was a war...I was like I’d been through a terrible war, a terrible thing.”

**Loss of trust in his own mind.** After finishing the outpatient program and trying to return to his life, Jeremy found that the treatment he received had instilled in him a terrifying belief, one that greatly hindered his recovery and that took him years to overcome:

The most terrifying thing that the mental health system did to me was that they made me feel as if I could not trust myself. I could not trust my own mind, because it might happen again...and you have to watch...you can’t be too stressed out, and...that took about 3 years to get over really, that kind of seed they planted.

As a result of this new belief with which he had been inculcated, he began to have panic attacks:

I never had panic attacks before in my life. I started to have panic attacks...The first one I had was when I went...I was still in the outpatient program, or maybe I was just getting out. I think I was in the outpatient for like a couple weeks, but I had to somehow take a bus up to Boston to like deal with my student housing, and I remember walking into the student union...and there are all these students in there, and I felt so incredibly alone and isolated that it was...I pan...I
just..I think I just..it was the terror, you know, I was terrified, utterly terrified . . . .
It was like, here are all these people bustling about, seemingly fitting into the
social order, having a task, and here I am, I just got out of the mental hospital, and
I’ve been told I have some kind of a brain disorder and made to feel as if there’s
something extremely, deeply wrong with me, and that it could possibly be there
for a long time..forever, and was I gonna..could I ever fit back in.

**Recovery.**

**Support from family.** Even though there were aspects of his family dynamics that
were not so supportive, Jeremy acknowledges that their support was crucial at times,
especially during his stay in the hospital:

My family did come through for me in important ways even when I was in the
hospital. My grandfather came to visit me every day and brought me good Italian
food, while my grandmother took me out to eat when I was allowed out on day
passes. My mother brought me clay and art supplies. My father visited or called
me every day, simply to check up on me and listen to my concerns and worries.
An aunt . . . and step-uncle brought me a CD player with some of my favorite
music. It was their simple, repeated, and thoughtful actions that made a
difference, In short, they helped me to restore my humanity. I shudder to think
how much worse it would have been had they not come through for me. They
made me feel like I had worth, at the time in my life when I thought I was
worthless.

**Being believed in.** Jeremy believes that one of the most important factors in his
recovery was choosing to return to school (back in the U.S. now), a choice that was
encouraged by one of the staffers in the outpatient program. Even though Jeremy’s
interactions with this staffer were relatively minor, the fact that someone believed in him
in this way provided a crucial turning point in Jeremy’s recovery:

There was one staffer over there who I do credit with..um..possibly having really
unwittingly, or maybe wittingly, turned things around for me because he set me
down in his office and he said, you need to go back to school, and I was like,
what, school, huh? . . . . He said, no, no, no, let’s get you enrolled, let’s get you
some special housing..um..he really believed in me, and if he hadn’t done that,
I..I’m quite sure I would have wound up..um..being a long-term mental health
client, or my..my stay in the mental health system would have been a lot, lot
longer.
**Putting the gears back in motion.** During the early stages of his recovery, Jeremy found that returning to school and just going through the motions of being a student again helped him to reconnect with a sense of purpose, in spite of the fact that this purpose initially felt somewhat superficial: “Just being back at [the university] and just walking around and doing my life in that superficial way was really important, like putting, you know, the gears back in motion to a machine that [laughs] needed to...I don’t know, you know, keep turning. That was...that was big.”

**Minimizing contact with his family.** Jeremy believes that, considering his extreme vulnerability, his tendency to take on the role of family savior, and the challenges he had with both his mother and his father (who were divorced and lived separately), returning home at that point would have been a grave mistake. College offered him a viable alternative, yet another of the many ways that returning to college supported his recovery:

> It was so important for me to go back to college right after my breakdown. If I had taken a leave of absence and gone back to live with one of my parents, I would have unwittingly placed myself right at the center of the cyclone. True to my family role, I would have continued my misguided attempts to heal them at the sacrifice of my own wellbeing.

**Exploring the root conflicts with a good therapist.** Jeremy believes that finding a good therapist was another very important factor in his recovery: “I did get into therapy, and that was big. That was big.” Jeremy was not open to discussing his psychosis in therapy (“because the psychiatry people fucked up so royally”); however, he believes that would not necessarily have been the most helpful thing anyway: “In some way, he just kind of bypassed all that anyway and got to the more root stuff of, you know, . . . the real
conflicts that were driving a lot of my anxiety in the first place, so we kind of just got
down to business, so it was really..it was really helpful.”

Jeremy believes that among the most helpful qualities of his therapist were his
high capacity for tolerance and his choice not to push the medical model:

He was a good therapist . . . . By that point, I was completely..um..like..you know, schizoid . . . would be the correct psychoanalytic term for what I was….I had to
control the whole..the whole session . . . . I was extremely critical of him and what he would say. But he knew to handle me with kid gloves and like be gentle and let me control the session, you know, and never be forceful about things, or be
forceful in the right way. I mean he just was a very good therapist. I just really
lucked out. He never was like, well let’s talk about your . . . mental illness, you
know, or like, how are you doing with your meds, you know.

Reconnecting with his father.  Jeremy believes that one of the most important
way that his therapist helped him was in exploring many of the core family dynamics that
Jeremy believes may have contributed to his development of psychosis. One dynamic in
particular that Jeremy was able to address in therapy and get support around was the
disconnection between him and his father:

Jeremy: There was a point where I think I had just lost a lot of contact with my
dad, probably after going away to college. I mean I never was super close..there
was maybe a time in like childhood where like he helped me with sports and took
a real interest, but, you know, he was kind of a…you know, he’s alcoholic, and he
has his own family trauma, and..um . . . he’s kind of a limited man emotionally,
you know. I think he does the best he can, but, you know, . . . because of his own
damage, he..we never could talk about our relationship..him and mine, and have
any real intimacy, you know . . . . So my therapist put his finger right on that,
and..um..helped me understand that, helped me understand that I could do
something to change that..um . . . maybe I could begin to talk to my dad about the
feelings that I have about him and about his drinking and risk,.risk doing that, and
I did. You know . . . the next time I got together with my dad, he came up to visit
me, you know . . . I started talking to him. It was very uncomfortable. I don’t
think that he knew what to quite do with that talking, but, you know, he hung in
there, and he didn’t..he, you know, heard what I was saying, and it was a real
healing..you know, that really sort of changed the course of my father and I’s
relationship profoundly.

Researcher: So, that sounds like, just that in itself was probably helpful in your
own recovery?
Jeremy: Totally.

**Challenging the medical model of psychosis.** Jeremy believes that another very important factor in his recovery was his challenging the belief that he was suffering from a brain disease. He expressed his gratitude for the role his girlfriend at the time played in this process:

And you know, I...I got lucky again ‘cause my girlfriend at the time would challenge me on that. She’d be like, you don’t have a brain disorder, what are you talking about. And I’d be like, oh, right, thank you, thank you, and then I go read antipsychiatry, you know [laughs].

Jeremy still expresses a lot of frustration about the harm caused to him and others by the mental health professionals who try to convince those suffering from psychosis that they have a lifelong brain disease:

Researcher: So, it sounds like you went through a period of time where you were kind of semi sort of buying that..that framework of having a broken brain--
Jeremy: Oh, for sure.
Researcher: --and having a lifelong disorder.
Jeremy: Yeah, the vulnerability. That’s what’s fu...that’s what’s evil about these fucking people. Their people are so vulnerable at that point that you’ll just buy about anything just to get some freakin’ coherence.
Researcher: Yeah, just to get some sense of ground, some sense of, right, stability, coherence, even if that ground comes with this absolutely awful story of hopelessness, it sounds like.
Jeremy: Bingo.

**Finding meaning.** Jeremy went through a profound struggle trying to reconnect with meaning and purpose after his experiences, a process that has taken place on several different levels. On one level, Jeremy worked hard to make sense out of his experiences—“the meaning of what the hell just happened to me.” He experiences tremendous frustration at the lack of support offered by the mental health care system in this regard:
So it’s 2010. It’s 2010. So, this happened in 1995, so 15 years later, I’m finally feeling like all the pieces of my story can be said out loud. I mean, I’ve said them to myself in various ways, but if we had a truly enlightened system, I would have been encouraged to put all that together as best I could within a...you know, getting on the inpatient unit.

On another level, Jeremy has struggled with how to make a meaningful life for himself after what he has been through. He found that what has really worked for him in this regard was to direct his entire life towards his own healing and the healing of others who have had similar experiences:

Jeremy: I just, you know, I just made my life a reaction and a healing...a deepening...that’s what it was. I...I turned all my energies towards absorbing this process and...uh...absorbing and metabolizing it, and coming up with creative ways to help others...um...maybe [laughs] it’s kind of an extreme case, but like everything I do is in some way related to that thing.

Researcher: The thing being kind of that goal of wanting to contribute.

Jeremy: Yeah. Yeah. I mean it just drives me. It drives my waking life...I have a purpose...I...I mean, it does flag, I’m not gonna lie, because I get demoralized, but...at the end of the day, it’s what I live for, you know.

**Lasting personal paradigm shifts.**

**Seeing the frailty of our cognitive constructs.** While in his psychosis, Jeremy had the profound experience of seeing “consensus reality [as] a veil”; and while the nonconsensus belief system that dominated his consciousness at the time has faded away, his belief that our cognitive constructs of the world are essentially veils has remained. Jeremy finds that his current understanding of the world resonates closely with Heidegger’s conception of the world as fundamentally mysterious, and this fundamental mystery requires that we construct *gestells*, or artificial frameworks, in order to keep us at a safe distance from the terror of that mystery:

I guess I’ve become more Heideggerian about all this, that there’s the mystery...the mystery and, you know, being...being is fundamentally mysterious, and we...we...um...uncover certain things about being because we happen to care about certain aspects of our existence, and so...but...but we cannot penetrate ever...
into the mystery of that being. We can...we can kind of open stuff here and there and get into it... Once you break out of the gestell, a whole world of phenomena starts to...you know, a whole world of beings become apparent that were hidden. There’s too much anxiety...it’s the anxiety that keeps people from opening up those levels... I guess maybe the way I’ve worked it out is like humans are necessarily a frail kind of fragile sort of very limited being in this space of... awe, the awesomeness of the universe, you know, and...um...we just sort of cobble together little rafts and ride them around, and that’s the best we can possibly do.

**A new perspective of good and evil.** During Jeremy’s recovery, his view of good and evil has changed considerably. Whereas within the depths of his psychosis, he saw good and evil in a very polarized way, he has now come to believe that perhaps a more helpful way to view these kinds of forces is as different degrees of tolerance to the anxiety of mystery. He has come to believe that people who have particularly rigid belief structures, such as those who subscribe to positivism and/or the medical model of mental illness, often have a particularly low tolerance for the anxiety of mystery:

Maybe some of the ways I think about it now is that there’s just people who don’t have that capacity [to tolerate the anxiety of mystery]... I don’t know where that comes from, but, you know, and they just kind of struggle, and um...they buy into this positivistic worldview... It’s not that they’re evil. I don’t see that they’re evil and I’m good, because there’s knowledge, you know, there’s levels of knowledge that I’m sure I [would] be too anxious to get in touch with, as well... I feel that those people are actually very wounded people who, you know, desperately want their own sense of...I mean most psychiatrists who buy into the medical model, they’d be the first to pop a pill or have their daughter or son pop a pill. I mean these people buy into this wholeheartedly, so it’s not, you know...um...I think that, in some senses, they...they...it’s too painful for them to...to kind of look that deeply inside themselves.

**Discovering a unifying primordial ground.** Jeremy’s profound journey through psychosis left him with a sense of the world as dichotomy arising from a unifying primordial ground:

I wonder if having gone through a psychotic episode and come out the other side—that is, having my Self implode into fragments and then slowly coalesce back—has profoundly imprinted something into my ongoing sensibilities. Perhaps an
appreciation of chaos and order, affirmation and negation, or some kind of similar dichotomy. Whatever it was I encountered, I can’t help but feel that it was a kind of primordial ground that unifies a good deal of phenomena.

**A widening of the spectrum of feelings.** Jeremy has discovered that, as a result of his psychotic process and recovery, the range and depth of feelings available to him has increased:

**Researcher:** So you kind of experience the whole spectrum [of feeling] more...more deeply, is that...do you think I have that right?

**Jeremy:** I think that that is very accurate, actually. I think that is...that is very, very true. When I experience pain and sadness, it’s intense, and when I experience joy...yeah, the widening of that capacity to feel is..uh..right, that’s right.

**The fruition of his desire to help others.** From a very young age, Jeremy has felt a strong desire to help others, and indeed, this desire was a core theme in his psychosis. However, after coming through this process, he discovered that he has developed the capacity to contribute to others in a very genuine way:

All these experiences ultimately convinced me to go to become a psychotherapist myself. I mean...you know, I ended up devoting my life to helping, you know, helping people in emotional distress, right, so it’s like, that’s the hugest part. I mean it was real. I turned this whole...and in a way, you know, it’s an experience that I almost would never trade...trade away for anything because...I mean the experience of going through a psychiatric hospital and being stigmatized and all this jazz, because it...it essentially set the course of my life in a very profound way, and...um...I realized that, you know, oh my god, here’s what I have to contribute.

**Seeing psychosis as a natural organizing process of the psyche.** After having gone through psychosis himself and then spending many years supporting others going through psychosis, Jeremy’s understanding of various aspects of psychosis has deepened considerably. One conclusion he has come to is that, ultimately, psychosis is a desperate coping strategy in the face of overwhelming thoughts and feelings:

What is called psychosis, let’s just call it psychosis, what it appears to me, is an activity that the psyche has taken up in order to achieve some kind of balance,
some kind of safety so that people can live in their own brains in order to organize this mass of chaotic feelings and thoughts and overwhelming..even positive feelings..um..sexual feelings, erotic feelings. And the thing you don’t want to do is to try to shame people for having that reaction, and you certainly don’t want to make them feel bad about it, because that’s the way that they’ve learned..that’s how they’re coping, and you do not want to take people’s coping mechanisms away.

Seeing a link between isolation and psychosis. Jeremy has also come to believe that the process of individuation from one’s family makes one particularly vulnerable to psychosis, especially when one’s family dynamics are idiosyncratic in a way that predisposes one to becoming isolated:

There is no mistake as to why this hits people around the 20’s. People are trying to individuate from their families, and..um..a lot of times, they come out of a family system that behaves in its own idiosyncratic, peculiar way, and some people’s families and family dynamics are actually very peculiar and very idiosyncratic, and when they go out into the world, they’ve been programmed, they’ve been trained. All their social stuff is coming from the family, and maybe, you know, maybe their family..um..maybe the family wasn’t so outgoing, maybe the family was kind of isolated and didn’t have a lot of friends, and maybe that kid didn’t really know how to kind of, you know, get into a social group and really make themselves like, and..um..what happens to them is they get out into the big bad world and they become isolated. They become completely alone.

This isolation, Jeremy believes, is an important factor in making someone vulnerable to psychosis:

When you meet somebody who has been labeled with a mental disorder, they’re often incredibly isolated people, and that’s no coincidence either. First of all, they have the stigma of having a mental disorder, which in itself throws you right out of the loop of society..it’s incredibly stigmatizing, and, you know, you’re thrown out. You’re an outcast, it’s incredibly painful. I know it because I struggled with that. I thought, oh my god, am I ever gonna be able to work again? I can’t handle stress? So there’s that going on, but even more than that, these people are just very lonely people, and they were..they’ve been lonely for a long time, and..um..it’s no wonder why they’re still lonely, and that’s all reinforcing what’s going on for them.

Appreciating the importance of healthy relationship for recovery. Because Jeremy believes that isolation is such an important factor in developing psychosis, he
believes that one of the most important factors in supporting those suffering from psychosis is the development of healthy relationship:

With clinicians today, they aren’t trained in relationship, I mean, they don’t…it’s about cognitive-behavioral, and it’s about doing things to people. It’s about technique, and it’s about..there’s just not an emphasis on the primacy of relationship in the system, and we have to start from relationship.

**Lasting benefits.**

**Increased confidence and assertiveness.** Jeremy said, “[I have] far more confidence [and] assertiveness . . . than I did before my psychotic episode.”

**A greater tolerance of mystery.** As mentioned above, Jeremy has come to believe that the world is fundamentally mysterious, and that touching into deeper layers of the world and ourselves entails confronting anxiety related to that mystery. In his own experiences, he believes that he experienced a very profound confrontation with this mystery and the associated anxiety, and as a result of recovery from those experiences, he believes he has developed a much higher tolerance for that anxiety:

*Researcher:* As you came through this process yourself, would you say that your tolerance of mystery has increased?
*Jeremy:* Um..I would say so, yeah, for sure, I mean, definitely [laughs]. Yeah, yeah, and I mean that I probably have my good days and my bad days with it, but [laughs].

**Increased resilience.** Jeremy readily acknowledges still experiencing difficult emotions in his life, and even occasionally getting somewhat swept away by them. He finds that his awareness of deeper dimensions of experience have increased significantly, which brings with it the possibility of more powerful feelings. On the other hand, he believes that his capacity to return to center and integrate them has increased significantly:
Researcher: So you have this much broader sort of spectrum now of experience than you had before, would you say your capacity to kind of bounce back to a kind of equanimity has kind of increased?
Jeremy: Yeah, yeah, I mean . . . . Well, I think yes and no. I mean, this is part of . . . . I think that the anxieties can maybe, you know, the anxieties can get too great, where I could be swept away more than I want to . . . . but when I come back, I have a framework in which to integrate it all. I’m like, oh wow, like look at the ride.

More wholesome, easeful relationships. Jeremy believes that his journey through psychosis and recovery has resulted in a deeper understanding of the value and nature of relationships: “I cherish the value of human relationships to a far greater degree. I also now understand that relationships are messy and complicated affairs, people hurt each other from their own hurts, and that I don’t have to take on other people’s pain to be loved.” He does not feel that his empathy or compassion has necessarily increased since prior to the onset of his psychosis, since he feels these were always quite strong; however, he feels that the motivation behind these has changed significantly:

    I do think I was always a pretty empathic person, even before the psychosis. However, I think it was motivated by having to make other people feel comforted. I think I was hampered in my understanding of other people’s motivations because of this. My psychosis I think had the effect of magnifying my need to "save" other people. If anything, I needed more of a capacity to become ruthless at the appropriate times.

Because of these and other similar changes that have resulted from his psychotic process, Jeremy feels that his overall ability to have healthy relationships has improved dramatically:

    I think it is somewhat of a night and day comparison. I feel like a whole person in relationship with whole people. Before, I would constantly ruminate over things I said or did, worried that I would offend people. It was like I was fighting a battle to be connected with others. Now I assume that connection is going to happen and I don't have to be too over-anxious about it.
Lasting harms: A narrowing of possibilities as a result of an increased sense of purpose. Jeremy expressed having one significant harm as a result of his psychosis that he continues to experience in his life. This harm, ironically, is actually the flipside of the benefit of having connected with himself and a sense of purpose in a deeper and more meaningful way:

To really take yourself seriously, there’s a special kind of pain that... that it entails... you know... In some ways, my affirmation of who I am is also, I realize now, a closing down. It’s a shutting off. I am not going to be... um... x, y, and z. You know, I’m not gonna... I couldn’t go out and be a restaurateur and open up a cool... I mean, I waited tables for like ten years, you know... at some of the nicest restaurants. I mean I have an incredible culinary background, but like that part of me... I love food, I love wine... I will never develop that, you know, like... we’re in a recession and I’m doing well, considering, but, you know, a couple of clients leave, I have my daughter, we’re stressed financially... you know, it starts to feel like, fuck, like here I am, my whole identity... it’s like this steamship that sets out for a port, you know, it’s like this steamship, once that sucker gets in motion, it’s hard to change course, and if that steamship kind of runs aground, you know, it’s like, ouch, man, ahh, I built everything. Everything is up, you know, 120 percent of myself is into this, and it’s painful, fucking painful.

Posttraumatic Growth Inventory Results

The PTGI (Tedeschi & Calhoun, 1996) is a standardized instrument that attempts to measure the benefits of a traumatic crisis, which in this case refers to the psychotic process itself. After thorough factor analysis, the final product of the PTGI consists of a total of 21 questions that are divided among five factors: relating to others, new possibilities, personal strength, spiritual change, and appreciation of life. Following are the possible scores for each factor:

1 = I did not experience any beneficial change as a result of my crisis.
2 = I experienced a very small degree of beneficial change as a result of my crisis.
3 = I experienced a small degree of beneficial change as a result of my crisis.
4 = I experienced a moderate degree of beneficial change as a result of my crisis.
5 = I experienced a great degree of beneficial change as a result of my crisis.
6 = I experienced a very great degree of beneficial change as a result of my crisis.
Table 5

Comparison of the Participants' PTGI Results

<table>
<thead>
<tr>
<th>Factor</th>
<th>Sam</th>
<th>Trent</th>
<th>Theresa</th>
<th>Byron</th>
<th>Cheryl</th>
<th>Jeremy</th>
<th>All Part.s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relating to Others</td>
<td>4.4</td>
<td>4.4</td>
<td>4.9</td>
<td>4.3</td>
<td>5.4</td>
<td>4.4</td>
<td>4.6</td>
</tr>
<tr>
<td>New Possibilities</td>
<td>5.4</td>
<td>5.2</td>
<td>4.6</td>
<td>4.4</td>
<td>4.4</td>
<td>5.6</td>
<td>4.9</td>
</tr>
<tr>
<td>Personal Strength</td>
<td>5.8</td>
<td>5.8</td>
<td>4.5</td>
<td>6.0</td>
<td>6.0</td>
<td>4.3</td>
<td>5.2</td>
</tr>
<tr>
<td>Spiritual Change</td>
<td>6.0</td>
<td>6.0</td>
<td>3.5</td>
<td>6.0</td>
<td>6.0</td>
<td>3.0</td>
<td>5.1</td>
</tr>
<tr>
<td>Appreciation of Life</td>
<td>6.0</td>
<td>5.3</td>
<td>3.0</td>
<td>6.0</td>
<td>6.0</td>
<td>4.7</td>
<td>5.1</td>
</tr>
<tr>
<td>Mean</td>
<td>5.5</td>
<td>5.3</td>
<td>4.1</td>
<td>5.0</td>
<td>5.6</td>
<td>4.4</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Note. All results are rounded down to two significant digits.

All participants’ scores for the five factors plus their overall mean score (the results are rounded to two significant digits) are listed in Table 5. It is interesting to note that all six participants experienced at least a small degree of beneficial change in all five factors as a direct result of their psychotic process, and that four of the participants experienced at least a moderate degree of change in all five factors. When the mean scores for all factors are taken into consideration (the bottommost row of Table 5), we arrive at a score that gives us a sense of the participants’ overall change as a result of their psychosis. When rounding the mean score to one significant digit, we find that two of the participants experienced an overall “moderate degree of beneficial change” as a result of their psychosis, two participants experienced an overall “great degree of beneficial change,” and two participants experienced an overall “very great degree of beneficial change.” These results match the qualitative data very well. Within the qualitative data, all participants expressed experiencing much more lasting benefit than harm as a result of having gone through their psychosis.
When taking into consideration the mean score of all participants for each factor (the rightmost column in Table 5), we find that all five of these factors are very close. When rounded to one significant digit, we see that the mean for all five factors is 5, which corresponds to a “great degree of beneficial change” for every factor. It does not appear, then, that there is any significant difference between any of these factors, generally speaking.

The PTGI results suggest that all six participants experienced a significant degree of overall benefit in many ways as a result of their psychosis, and while this is in direct alignment with the qualitative results, it is important to keep in mind that a couple of the participants (Theresa and Byron, in particular) expressed the challenge of trying to capture their experiences within such a constrained quantitative measurement. Byron also expressed that he has continued to experience significant growth since the point at which he would be considered fully recovered (according to the definitions used in this study), so he found it challenging to draw the line between the growth he had experienced as a result of his psychotic process and the growth that he experienced afterwards. Still, having accounted for these limitations, the degree of growth that all participants expressed experiencing as a result of their psychotic process is striking, especially when we consider the widely prevalent myth within Western society (Mackler, 2008) that very few people return to one’s pre-psychotic level of wellbeing and functioning, let alone experience such tremendous growth.
Cross Case Analysis

In performing cross case analysis of the data from these participants, I arrived at a set of themes for each category of experience—description of the anomalous experiences, onset and deepening of psychosis, recovery, lasting personal paradigm shifts, lasting benefits, and lasting harms. Table 6 lists the converging themes for each category along with their associated divergences. Following is a detailed outline of all of these themes, including the most relevant data pertaining to that theme for each participant:

Description of the Anomalous Experiences

Polarized experiences of good and evil. All participants experienced a polarization of good and evil within their anomalous experiences, though the details vary significantly.

- Sam experienced the good and evil of war—the good of stopping evil forces in the world but the evil of causing destruction and harm in the process, as well as the evil of being harmed. He also experienced the good and evil of the “initials agencies” (such as the FBI and CIA)—the good of catching evil criminals, but the evil of being hunted by these agencies.

- Trent experienced messages of God offering him guidance, but was also persecuted by the devil, the “satanic” energies of whom completely “immersed” him at one point.

- Theresa had profound experiences of Heaven and Hell during her first episode, and experiences of being watched over by both good/benevolent and evil/malevolent entities.
Table 6. *Converging Themes and their Associated Divergences*

<table>
<thead>
<tr>
<th>Description of Anomalous Experiences</th>
<th>Converging Themes</th>
<th>Divergences</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Polarized experiences of good and evil</td>
<td>(1) All experienced this.</td>
<td></td>
</tr>
<tr>
<td>(2) Creative and destructive forces</td>
<td>(2) All experienced this.</td>
<td></td>
</tr>
<tr>
<td>(3) Fluctuating between omnipotence and powerlessness</td>
<td>(3) All experienced this.</td>
<td></td>
</tr>
<tr>
<td>(4) Heroic striving (fighting evil and/or ignorance)</td>
<td>(4) Trent and Cheryl experienced striving against evil forces within themselves; and all except for Cheryl experienced striving against evil and/or suffering &quot;out in the world.&quot;</td>
<td></td>
</tr>
<tr>
<td>(5) Being watched over by malevolent and/or benevolent entities</td>
<td>(5) All experienced this; however, Jeremy was the only one who did not experience both types (experiencing primarily malevolent watching over).</td>
<td></td>
</tr>
<tr>
<td>(6) Groundlessness</td>
<td>(6) All except Sam mentioned experiencing profound groundlessness.</td>
<td></td>
</tr>
<tr>
<td>(7) Parallel dimensions</td>
<td>(7) All but Trent experienced different realms of experience occurring simultaneously to some degree.</td>
<td></td>
</tr>
<tr>
<td>(8) Feelings of euphoria, liberation, and/or interconnectedness</td>
<td>(8) All but Sam recalled having these kinds of experiences, to a significantly greater or lesser degree. Jeremy had these just prior to his psychosis, but not so much after onset.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description of Onset and Deepening of Psychosis</th>
<th>Converging Themes</th>
<th>Divergences</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) An actual or existential threat to the self just prior to onset</td>
<td>(1) All experienced this.</td>
<td></td>
</tr>
<tr>
<td>(2) Childhood isolation</td>
<td>(2) All participants had a significant amount of isolation in their childhood, but to varying degrees.</td>
<td></td>
</tr>
<tr>
<td>(3) The significant use of recreational drugs prior to onset</td>
<td>(3) All but Cheryl had significant experiences with recreational drugs prior to onset.</td>
<td></td>
</tr>
<tr>
<td>(4) A swing between extreme isolation and extreme connection just prior to onset</td>
<td>(4) All but Sam and Trent had this kind of swing just prior to onset.</td>
<td></td>
</tr>
<tr>
<td>(5) A profound shift in one's personal paradigm just prior to onset</td>
<td>(5) All but Trent experienced profound shifts in this regard; Trent, however, did increase his marijuana use significantly just prior to onset, which may be closely related.</td>
<td></td>
</tr>
<tr>
<td>(6) Harm from the psychiatric system</td>
<td>(6) All experienced this.</td>
<td></td>
</tr>
<tr>
<td>Recovery</td>
<td>Converging Themes</td>
<td>Divergences</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>(1) Finding meaning</td>
<td>(1) All experienced this (though the details vary).</td>
</tr>
<tr>
<td></td>
<td>(2) Finding hope</td>
<td>(2) All experienced this (though the details vary). Meaning and hope seem closely related. Everyone but Sam expressed that making meaning of their experiences gave them hope.</td>
</tr>
<tr>
<td></td>
<td>(3) Finding self-connection/agency</td>
<td>(3) All experienced this (though the details vary).</td>
</tr>
<tr>
<td></td>
<td>(4) Healthy vs. unhealthy relationships</td>
<td>(4) All experienced this (though the details vary). Trent and Jeremy also expressed the importance of distancing themselves from unhealthy relationships; Byron was well into recovery before connecting with a particularly healthy relationship.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lasting Paradigm Shifts</th>
<th>Converging Themes</th>
<th>Divergences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1) An integration of good and evil</td>
<td>(1) All experience this.</td>
</tr>
<tr>
<td></td>
<td>(2) A significantly changed spectrum of feelings with more depth and unitive feelings</td>
<td>(2) All experience this.</td>
</tr>
<tr>
<td></td>
<td>(3) An increased experience of interconnectedness</td>
<td>(3) All experience this.</td>
</tr>
<tr>
<td></td>
<td>(4) A strong desire to contribute to the wellbeing of others</td>
<td>(4) All experience this.</td>
</tr>
<tr>
<td></td>
<td>(5) Appreciating the limits of consensus reality</td>
<td>(5) All experience this.</td>
</tr>
<tr>
<td></td>
<td>(6) A greater understanding of psychosis</td>
<td>(6) All experience this.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lasting Benefits</th>
<th>Converging Themes</th>
<th>Divergences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1) Greatly increased wellbeing</td>
<td>(1) All experience this.</td>
</tr>
<tr>
<td></td>
<td>(2) Greater equanimity</td>
<td>(2) All experience this.</td>
</tr>
<tr>
<td></td>
<td>(3) Greater resilience</td>
<td>(3) All experience this.</td>
</tr>
<tr>
<td></td>
<td>(4) Healthier relationship with oneself</td>
<td>(4) All experience this.</td>
</tr>
<tr>
<td></td>
<td>(5) Healthier, more rewarding relationships with others</td>
<td>(5) All experience this.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lasting Harms</th>
<th>Converging Themes</th>
<th>Divergences</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) (Each participant expressed a significantly different harm)</td>
<td>(1) All except Theresa expressed some lasting harm, though they all expressed experiencing much more benefit than harm overall.</td>
<td></td>
</tr>
</tbody>
</table>
Byron had numerous visions of the battle between good and evil forces, including being guided by the benevolent dakinis into the depths of the underworld, and going from the heavens to the hells to rescue prisoners and hospital patients from the psychiatric hospital. He also played an important role in bringing about the transition of the ages— from the Stone Age (the age of ignorance, and therefore evil in many contexts) to the Age of Aquarius (the age of wisdom, and therefore good in many contexts).

Cheryl experienced the good of benevolent and supportive spirit guides which then became profoundly evil and malevolent, followed eventually by the lasting sense that perhaps there is some benevolent and protective force in her life. She also had profound experiences of a God who despised the evil within her, threatening to send the entire world to hell because of her utter evilness.

Jeremy had an elaborate nonconsensus belief system comprised of the battle between the good forces of the “white order” and the evil forces of the “black order.”

**Creative and destructive forces.** All participants experienced both powerful creative and destructive forces, which were often closely related to good and evil.

Sam experienced the creative role of actively directing major movies, but he sometimes took on destructive roles in these scenarios (such as being the demolitions expert at one point). As an “initials” agent, he took on the very creative role of directing a complex assault operation in Iraq and in capturing D. B. Cooper, yet these roles often entailed severe destruction, such as bringing bombs down on the people of Iraq.
• Trent experienced periods of profound insights and creative intelligence and imagination, but he was also inundated with very violent and destructive “satanic thoughts” that resulted in him having a severe bout of “dry-heaving blood.”

• Theresa experienced profound creativity associated with the process of channeling a child and giving birth, and she spent significant time experiencing the destructive forces of Hell and fire.

• Cheryl experienced a period of profound creative intelligence and insights in which she felt she was on the verge of formulating a paradigm-shifting theory related to the illusion of time; and she also spent much time filled with the destructive energy of hatred, both directed towards herself and experienced as being directed from others (e.g., God, family members, her future husband).

• Byron had numerous visions of the death/rebirth process of his self and of the world, which entailed qualities of both profound creativity and profound destruction.

• Jeremy experienced profound creative intelligence when formulating a theory regarding the destructive forces in the world. His insights took him from realizing the destructive “war” within himself to seeing this enacted interpersonally in others and finally to seeing this war on a grand scale directed by the forces of the black order.

  **Fluctuation between omnipotence and powerlessness.** All participants expressed having fluctuations to a greater or lesser degree between feelings of omnipotence and feelings of powerlessness. (Ironically, they all express having felt extreme helplessness during their psychiatric treatment, though this, of course, was taking place within consensus reality.)
• Sam experienced the tremendous power of being a leading “initials” agent, a famous movie star, and movie director. He also experienced the powerlessness of being caught in a war and being hunted by the “initials agencies.”

• Trent experienced numerous fluctuations between feeling “godlike” on one hand and profound despair and/or terrifying persecution by the Devil on the other.

• Theresa went from the omnipotent sense that she could save others from suffering merely by overcoming certain challenges to feeling too powerless to even save herself while experiencing Hell in the psychiatric hospital. She also experienced significant powerless along with feelings of persecution during her second episode.

• Byron had experiences of carrying the entire weight of the world on his shoulder a times (both literally and figuratively), and at other times, feeling at the complete mercy of malevolent doctors.

• Cheryl felt that she was on the verge of a paradigm-shifting truth that could alter the course of mankind to feeling at the mercy of her spirit guides and a God seething with hatred for her.

• Jeremy went from the profound terror of utter self annihilation to a sense of omniscience and enlightenment, then to paranoia and persecution.

**Heroic striving (fighting evil).** All participants experienced a kind of heroic striving, especially in the sense of a mighty striving against evil. Trent and Cheryl experienced a somewhat different form of heroic striving than the others—whereas the others primarily experienced a striving against evil out in the world, Trent and Cheryl experienced a striving against the evil within themselves (and in Cheryl’s case, this was how she would save the world). Cheryl experienced primarily this kind of internally-
directed striving, whereas Trent experienced a significant amount of both internally-directed and externally-directed striving.

- Sam experienced the striving of having to do “certain things” to avoid global catastrophe. He also strove very heroically in his work for the “initials agencies” while pursuing criminals and also while directing strategic military operations against the evil forces within Iraq.

- Trent had experiences in which he believed that “the world would be free from its sufferings…because of something that I participated in. He also experienced intense striving against the evil and “satanic” forces within himself.

- Theresa found herself striving very heroically in overcoming various challenges as the means to prevent the suffering of others.

- Byron found himself performing rituals for world peace (e.g., “turning poison into nectar”) during a number of his visionary periods. He felt at one point in the visionary realm that he had literally taken the world on his shoulders (giving it to Heracles and taking it back again). At other times, he strove mightily to help transition the world into the age of Aquarius, and he made daring rescue attempts to rescue all beings from hell (which, in consensus reality, involved attempts to rescue the hospital patients from the psychiatric hospital).

- Cheryl strove to save the entire world by fighting the evil that was within herself. She also went through a period where she was conducting various rescue missions directed by her spirit guides, including attempting to rescue a juvenile delinquent from the rescue facility at which she worked.
• Jeremy strove to rescue the world from the evil forces of the black order, at one point going on a heroic quest to save his brother from these forces.

**Being watched over by malevolent and/or benevolent entities.** All participants seem to have experienced some degree of being watched over by benevolent and/or malevolent entities (thought not necessarily at the same time). Jeremy was the only participant who does not recall being watched over by both types of forces, having only experienced being watched over by a malevolent force. Sam had a slightly different experience than the others in that his benevolent watching over was somewhat less archetypal, taking the form of fellow “initials” agents and an enrapt audience when he was performing stunts for a movie.

• Sam experienced being watched over by non-malevolent entities as he starred and performed stunts in various movies, and as he communicated with intelligence agencies while carrying out various missions. He experienced a malevolent watching over in the form of being hunted by the initials agencies and assaulted by enemies in a war.

• Trent experienced being watched over and personally guided by a benevolent God, and he was also persecuted by the Devil, both from within and without.

• Theresa experienced the benevolent forces of a large black man in her closet and a guard dog protecting her, and she also experienced being persecuted by unknown malevolent entities.

• Byron experienced the guidance of the benevolent dakinis, and he experienced being imprisoned in hell and tormented by the doctors and the psychiatric establishment.
• Cheryl experienced a nearly constant watching over from spirit guides who began as benevolent, then became extremely malevolent, and finally left her with a residual sense of being protected by some benevolent force. She also experienced being persecuted by her father, her future husband, and others.

• Jeremy experienced being watched over and hunted by the black order. Although he sensed the presence of the white order, he did not experience their watching over him quite so acutely.

**Groundlessness.** All participants except for Sam recall having profound experiences of groundlessness, typically accompanied by terror, though occasionally accompanied by feelings of liberation, as in the cases of Byron and Cheryl, or deep despair, as in Trent’s case.

• Trent experienced his onset as “imploding into a void where a family was supposed to be,” resulting in a sense of profound despair and disconnection with himself and the world.

• Theresa recalls being “pretty much ‘groundless’ the whole time during both psychotic experiences”: “I didn’t even feel ‘physically’ connected to the ground most of the time…..of ‘psychically’ connected to the planet – and quite importantly (I think) didn’t feel connected to another human being thru pretty much the whole of the time.”

• Byron had powerful experiences of groundlessness throughout much of his psychosis, often accompanied with the sense of spiritual or bodily disintegration, terror, and at times rapture.
• Cheryl experienced extreme terror and groundlessness for the majority of the first two months of her psychosis.

• Jeremy experienced profound annihilation anxiety at the onset of his psychosis. It was relatively short-lived and resulted in a very quick flipping over into feelings of omniscience and enlightenment, what he believes was a compensatory reaction.

**Parallel dimensions.** All participants except for Trent expressed having experiences of different realms or dimensions of experience coexisting. The degree to which the participants experienced this varied significantly, with Sam on one extreme experiencing this regularly and intensely, and Trent on the other extreme not recalling anything like this happening at all—“It was clear boundaries between one experience to the next.”

• Sam had the strong sense most of the time that his various missions were taking place concurrently, like “parallel worlds.” He also occasionally had the experience of this happening with consensus reality, as when the hospital staff jumped on top of him, forming a “dog pile” after he had panicked at the psychiatric hospital. He recalls having the distinct awareness of what was taking place within consensus reality while also having the experience of being in a war “buried in people and rubble” after a bomb had gone off.

• Theresa described occasions in which “several different realities [were] happening at the same time [and] the boundaries weren’t clear at all.”

• Byron had a vision of bardo, in which he was descending through many concurrent layers of the world. He also had many visions in which he had some awareness of
what was happening in consensus reality but was also profoundly involved with what was happening within his visions.

- Cheryl had the experience at one point of seeing time as an illusion and perceiving that all of our past lives are existing concurrently with our current life. She also had times of having simultaneous awareness of the different layers of her experience—the “spirit guides,” her own sense of self and agency, the presence of hell, and consensus reality—and being profoundly confused by this.

- Jeremy did not recall having “layers” of experience in quite the same way as those mentioned above; however, he does recall “tracking two levels of phenomena at once,” in the sense of being aware to some extent of what was taking place within consensus reality, but then simultaneously being aware of applying a significantly alternative interpretation onto this.

**Feelings of euphoria, liberation and interconnectedness.** Trent, Theresa, and Byron, and Cheryl and Sam to a lesser extent, expressed having experienced feelings of euphoria, liberation and/or interconnectedness during their psychosis. Jeremy had such feelings prior to his psychosis, but not so much after the onset. *Interconnectedness*, as discussed here, refers to the experience that all manifestations of the universe, including oneself, are fundamentally interconnected.

- Sam does not recall having particularly strong experiences of liberation or euphoria during his psychosis, but he does recall having some profound experiences of interconnectedness: “I think spiritually I had always thought that all experiences and manifestations of the universe are interconnected. These experiences helped me to solidify these ideas in my mind.”
• Trent recalls having experiences of liberation, euphoria, and interconnectedness during his psychosis, even though these kinds of experiences were generally quite rare.

• Theresa had several experiences of profound universal expansiveness and interconnectedness.

• Byron had profound experiences of liberation and interconnectedness just prior to his psychosis, and he recalls that the initial stages were “full [and] enrapturing.” He recalls, however, that as his psychosis progressed, he primarily experiencing a fairly strong dualistic (self/other) split, although he “was intensely seeking to attain ‘unification’.”

• Cheryl did not recall strong feelings of interconnectedness per se, but she felt “mild euphoria and liberation” when first contacted by the “spirit guides.”

• Jeremy did not express experiencing interconnectedness per se, but during the few weeks leading up to his first psychotic experiences, he experienced fairly strong feelings of liberation, deep peace within himself, and intimate connection with others.

The Onset and Deepening of Psychosis

An actual or existential threat to the self just prior to onset. All participants experienced a threat to their self, either an actual bodily threat as in the case with Sam and perhaps Byron to some extent, or an existential threat, as in the case with the others. Cheryl and Jeremy experienced a profound sense of isolation, as perhaps did Trent to some extent, immediately prior to onset, and as will be discussed in the “Discussion” section, it is likely that overwhelming isolation can feel just as threatening to one’s sense of self as overwhelming connection.
- Sam had received a draft notice for the Vietnam War.
- Trent experienced a sense of “Imploding into a void where a family was supposed to be.”
- Theresa was overwhelmed by such a strong sense of connection at the kibbutz that she felt as though she were losing a sense of herself.
- Byron was actively seeking a death/rebirth process just prior to onset, and then just after experiencing some profoundly liberating anomalous experiences, he fell three stories onto his head, barely surviving, and awoke in the hospital to more distinctly psychotic experiences.
- Cheryl experienced profound and overwhelming isolation and despair just prior to onset.
- Jeremy experienced a profound and overwhelming shaming and associated isolation immediately prior to onset.

**Childhood isolation.** All participants expressed having experienced significant isolation in their childhood, an experience that several of them expressed was associated with feelings of profound shame.

- Sam felt significantly disconnected from his parents, especially in adolescence.
- Trent describes his family as “highly dysfunctional,” having a father who was chronically depressed and was often verbally and emotionally abusive, and a mother who had been diagnosed with paranoid schizophrenia.
- Theresa became very withdrawn and isolated at a very young age, and she expressed having layers of isolation stacked on top of each other culminating with the death of both of her parents in late adolescence.
• Byron’s relationship with his idiosyncratic mother made it difficult for him to fit in elsewhere, and he remained very isolated at school and with peers throughout the majority of his adolescence.

• Cheryl experienced emotional abuse and neglect from “immature” parents. As a result of this and perhaps other factors, she experienced significant shame, self hatred, and depression from a very early age.

• Jeremy was raised by an emotionally neglectful father and a verbally abusive mother who struggled with psychosis at times. He also experienced severe shaming and bullying in his adolescence.

The significant use of recreational drugs prior to onset. All participants except Cheryl expressed having consumed a significant amount of alcohol and other recreational drugs prior to the onset of their psychosis.

• Sam had used marijuana and alcohol relatively frequently for the three years leading up to the onset of his psychosis (from age 16 to 19). He also occasionally experimented with LSD during this time, though he did not use it at all in the six months prior to onset.

• Trent believes he was using marijuana “too often” prior to onset. Immediately prior to onset, a number of stressful incidents occurred in his life which led to his increasing his marijuana intake significantly as a means to cope with these stressors.

• Theresa consumed a significant amount of alcohol and hashish at the kibbutz immediately prior to the onset of her psychosis—“I practically just wasn’t sober.”
- Byron had been using LSD and other hallucinogens for some time prior to onset. He had a particularly profound experience while under the influence of LSD at the well-known Woodstock music festival just six weeks prior to onset.

- Jeremy had not been consuming a significant amount of drugs or alcohol prior to his onset; however, he was quite high on marijuana at the time of onset (during the shaming incident at the party that led to his experience of annihilation anxiety).

**A swing between extreme isolation and extreme connection just prior to onset.** A particularly interesting pattern shared by four of the participants is having experienced a swing from an extreme sense of isolation to an extreme experience of connection just prior to onset.

Sam and Trent did not express having experienced such a swing prior to their psychosis.

- After living a very isolated childhood and adolescence, which was greatly exacerbated by the death of both of her parents, Theresa quite suddenly became overwhelmed by the intensity of community and connection after arriving at the kibbutz.

- After an isolated childhood, Byron experienced profound connection (both with other peoples and also a more universal connection) at Woodstock via the aid of hallucinogens and the intense level of community in that environment.

- After a childhood filled with much shame and isolation, Jeremy experienced profound connection with himself and others after his insights into the inner war and the war between others. This continued until the night at the party when he had a profoundly shaming and isolating experience, leading very quickly to psychosis.
• After experiencing a lot of shame and isolation in her childhood, Cheryl experienced a series of highly shaming, isolating incidents that further exacerbated her sense of isolation. This was then followed by a sense of deep connection and support from her apparent contact with benevolent and supportive spirit guides as a result of her spiritual counseling class.

**A profound shift in one’s personal paradigm just prior to onset.** All participants except for Trent expressed having experienced a profound shift in their personal paradigm just prior to the onset of their psychosis. Trent did not seem to experience this so much; however, a series of particularly stressful incidents occurred immediately prior to onset, including his having to take care of his ex-girlfriend and 2-year-old son while still living with his dysfunctional family, which led to a significant increase in his consumption of marijuana as a means to cope with this.

• Sam received his draft notice for the Vietnam War just prior to onset. Considering the intensity of the war at that time and his involvement with peace activism, he found it impossible to integrate this news.

• The experience at the kibbutz profoundly changed Theresa’s experience of herself and the world, and she found that she was overwhelmed with trying to integrate into her personal paradigm that such connection was possible.

• After a very isolated youth, Byron was at first somewhat able to integrate the degree of connection he experienced with others as he came to identify as “a child of the 60’s.” However, he found it nearly impossible to integrate the profound experience of universal interconnectedness that he experienced while at Woodstock.
The spirit guides that contacted Cheryl during her spiritual counseling class were at first a pleasant anomalous experience (not causing significant distress and/or limiting her functioning) and were not therefore defined as psychotic according to the definitions of this study. However, this experience entailed a profound shift in her personal paradigm that she was unable to integrate, and it was followed by a relatively rapid descent into psychosis soon afterwards.

Jeremy went through a series of personal paradigm shifts prior to onset:
1. Coming to realize that the human race is not guided by wise elders.
2. Coming to realize he had been struggling with an intrapsychic war and that such awareness provided significant relief from it.
3. Coming to perceive that interpersonal relationships are plagued by self-esteem battles.

Each of these presented a challenge for Jeremy to integrate into his personal paradigm to a greater or lesser degree, the sum total of which apparently made him vulnerable to the psychosis that eventually took place.

Harm from the psychiatric system. All participants expressed having suffered severe harm and even trauma from their interactions with the psychiatric system. Only Sam and Trent found the psychiatric system to be of any significant help at all.

Sam experienced harm from the system on several different levels—physical abuse from the police officers when he was arrested for his psychotic behavior, increased fear and terror as a result of treatment within the hospital (feelings that he experienced very little outside of the hospital), and harm from the use of antipsychotics. He believes the sudden withdrawal of antipsychotics at times led to
psychotic experiences, and the long-term use of them greatly hindered his recovery; he does, however, believe that they were somewhat helpful when he was able to use them judiciously and for short periods of time during the end of his recovery.

- Trent expressed having received neglectful and abusive treatment while an inpatient resident at a psychiatric hospital, although he did find the therapy he received in outpatient treatment to be helpful. He also likely experienced withdrawal psychosis and other severe withdrawal symptoms as a result of antipsychotic use; however, like Sam, he feels the judicious short-term use of antipsychotics “might have helped.”

- Theresa described her experience in the hospital “as bad as if not worse than the trauma of anything that had actually caused [the psychosis].” She believes that receiving antipsychotics during her first episode interrupted a natural process, thereby necessitating a second psychotic episode.

- Byron suffered significantly by the generally poor care and strict imprisonment he received while in the hospital. He describes the antipsychotics as being a “poison” to him, believing they interfered significantly with his recovery process.

- Cheryl feels the psychiatrists were “not helpful at all” and that the antipsychotics were “irrelevant to recovery,” perhaps helping with sleep, but exacerbating her psychosis at times and causing physical problems. She also expressed the harm of the “myth of hopelessness” perpetuated by the psychiatric establishment, and expressed gratitude for having come across hopeful recovery research prior to her psychosis.

- Jeremy feels that he emerged from his hospitalization “a shell of a human being.” He struggled tremendously for several years thereafter with having been told that he
could never fully recover. “[It] made me feel as if I could not trust myself. I could not trust my own mind.”

Recovery

Finding meaning. All participants expressed their belief that finding meaning was particularly important for their recovery. They all expressed the importance of connecting with meaning in life, in general, and all but Sam expressed the importance of making sense of their psychosis. All participants except Trent have become professionals within the mental health field and are now working directly with people suffering from extreme states, finding that being able to contribute in this way has provided important meaning for them.

- After coming off the antipsychotics about ten years after his first psychotic episode, Sam was able to return to college, obtain a bachelor’s degree, and find a meaningful career within the mental health field.

- Trent has found meaning in his life by channeling the creativity he tapped into within his psychosis towards expressive arts, especially writing, poetry, and photography. He also found that making sense of the roots of his psychosis via group and individual psychotherapy, reading, introspection, and contemplation has been helpful.

- Theresa has found meaning in her life by creating a healthy family and also by becoming a professional within the mental health field. She also found it helpful to make sense of her psychosis and related experiences with the help of an individual psychotherapist.

- Byron first began to connect with some meaning, both in regard to his psychotic experiences and in life in general, when he read Be Here Now by Ram Dass. He
continued to find meaning within spiritual traditions, eventually arriving at Tibetan Buddhism and a supportive teacher. He has also found some important meaning working within the mental health field.

- Cheryl first found some important meaning for her experiences when she met a psychic who described her experiences in a way that resonated with her. She worked within the mental health field both before and after her psychosis, and reconnecting with this work in a more meaningful way afterwards has been particularly helpful to her.

- Jeremy found a “very good therapist” who was able to help him explore the roots of his psychosis, which he found very helpful. He has since devoted his life to the work of developing more helpful ways of supporting people who suffer from psychosis.

**Finding hope.** All participants expressed that connecting with hope was an important part of their recovery. Also, meaning and hope seem to be closely related for most of these participants—all but Sam expressed that making meaning of their experiences gave them hope.

- Sam found significant hope when he realized that he did not have to remain on antipsychotics forever. He realized he could use them on as-needed basis, which he did for several years, and return to a full life.

- Trent expressed that what gave him hope was being able to recognize the healing that was taking place for him with the passage of time: “Knowing I felt better than I did a month or two previously gave hope.”

- Theresa’s first moment of hope came when she realized that other people had very similar experiences to what she was experiencing—that she was not a “freak.” She
had another important experience of hope when she met the psychiatric survivors, then again after “hitting bottom” and realizing there was nowhere to go but up, and again when finding a supportive partner. She also expressed feeling hope when she realized her psychosis had a purpose, which she believes was to heal her so that she could have a family.

- Byron found both hope and meaning when he connected to a spiritual path and then eventually with Tibetan Buddhism, which provided him with a particularly good framework for making sense of his experiences.

- Cheryl was fortunate to have read the WHO recovery studies prior to her psychosis, and so she had some hope all along that it was possible to fully recover. Later, when she felt immediate relief after a healer performed an “exorcism” on her, she experienced some hope that she could actually improve. Then, when a psychic explained her experiences in a way that made sense to her, she experienced further hope. She experienced further hope when her cat demonstrated that she really was lovable.

- Jeremy felt the first spark of hope when a therapist at the day hospital “believed in [him]” and encouraged him to return to school. Then, his hope increased as he challenged the medical model and began to believe that full recovery really was possible.

**Finding self-connection/agency.** All participants expressed that connecting with their self and their sense of agency was very important in their recovery.

- Sam was first able to reconnect with his “spark” after coming off the antipsychotics. He also used self-hypnosis tapes, which helped him cultivate self esteem and
confidence, he learned the value of self care, and he began to turn to a number of different creative outlets such as writing and playing music as a way to connect with his own aliveness.

- Trent found his voice and authenticity during psychotherapy and then in his relationships with others. He also gave up marijuana and cigarettes and learned how to be with himself without the need for chemical aids.

- Ironically, for Theresa, becoming pregnant was an important factor in connecting with herself and finding her sense of agency. Although many might see her manner of becoming pregnant as highly irresponsible (having done so with a short-term partner), this represented the beginning of a genuine sense of connection with herself and her dream of a family which ultimately initiated the motivation and agency necessary to do the hard work of recovery.

- Byron was able to find his sense of agency and some grounding for his anomalous experiences with the help of meditation and other contemplative practices.

- Cheryl found her agency when she stood up to the voices, insisting that she would not let them rule her life anymore. Shortly thereafter, she began to intentionally practice self-love and self-forgiveness, which furthered her self connection and sense of agency.

- Jeremy found that returning to school was a very important turning point, making the effort to “put…the gears back in motion” even when he was still in the midst of his profound struggle. His sense of self connection and agency continued to grow as he focused his energy on the healing of himself and others.
Healthy vs. unhealthy relationships. All participants mentioned the importance of developing healthy relationships as an important part of their recovery. Trent and Jeremy also expressed the importance of creating distance from unhealthy relationships. Sam expressed how important it was to have loved ones willing to stand by his side when things got difficult.

- Theresa was fortunate to have come across a group of psychiatric survivors while she was homeless on the street and still struggling with intense psychotic experiences. Shortly afterward, she met the man who would become her lifelong partner, and his support and care for her played a very important role in her recovery.

- After Byron had recovered significantly, he met the woman who would become his lifelong partner, and her love and support was very important in his ongoing recovery.

- While Cheryl had significant problems with her parents when younger, she feels that they came through for her during her psychosis, supporting her in finding alternatives to psychiatry and being steadfast in their love and support for her even while she was insistently declaring that they must hate her and even want to see her dead.

- Jeremy received significant support from his friends and family while in the hospital, which he believes greatly reduced the harm he otherwise might have experienced there. He also realized that creating distance between himself and his family after getting out of the hospital was important for his recovery, since he came to recognize particularly unhealthy dynamics in his family system that likely played a role in the onset of his psychosis. He also developed a supportive relationship with a romantic
partner, and he was able to create a much healthier relationship with his father with the help of a therapist.

- Trent was able to cultivate several relatively healthy long-term romantic relationships during recovery that were supportive. He also created some distance between himself and his family, wanting to avoid returning to the dysfunctional relationships there that he feels played a significant role in the onset of his psychosis.

**Lasting Personal Paradigm Shifts**

**An integration of good and evil.** All participants expressed having a different understanding of good and evil as a result of having come through their psychosis. While all of them have come to somewhat different understandings in the regard, it appears that they all share several common themes in this regard. They have come to see good and evil in a more integrated and less polarized way, and they have all come to distinguish evil acts from evil people, believing that evil is not something that is innate within people, but that evil acts result from those who are particularly ignorant or wounded.

- Sam finds that he is able to more easily see the humanity in others now, even those who have committed very harmful acts. He sees evil as acts that are caused by people who “need as much of healing of their soul as they can get,” and he finds that he enjoys working with such wounded people.

- Trent has come to see good as that which arises when one is connected with the true heart and evil as that which arises when the true heart is obstructed. He sees the true heart as the heart that we all share; therefore, he now sees that everyone has the capacity to connect with the true heart.
• Theresa has come to believe that there is valid meaning behind any act, whether harmful or not, and that validating and understanding the person’s experience provides more guidance for how to deal with any problems than judging whether or not something is good or evil. Her choice of profession, which is within the field of forensics psychology, is closely related to her beliefs in this regard.

• Byron has come to embody the Buddhist perspective that evil (i.e., harmful) acts are done out of ignorance of the true nature of the world, and that everyone struggles with this ignorance to a greater or lesser degree.

• Cheryl has come to see the world as “not so black and white anymore,” seeing evil actions as caused by people who are not inherently evil but are “wounded or ignorant in some other way.”

• Jeremy has come to see good and evil as different degrees of tolerance to the anxiety of mystery. He has come to believe that people who have particularly rigid belief structures, such as those who subscribe to positivism and/or the medical model of mental illness, are likely to have a particularly low tolerance for the anxiety of mystery.

A significantly changed spectrum of feelings with more depth and unitive feelings. All participants have expressed that the spectrum of feelings that are available to them now has changed significantly since prior to their psychosis, especially towards having more unitive feelings and experiencing other feelings with more depth and richness.

• Sam feels he experiences more “bliss” and general contentment in his life now.
• Trent describes his “vision” as being much less limited now. He experiences much more fulfillment, beauty, and possibilities in the world now. Along with this, he has a greatly increased appreciation for creativity—of himself, others, and the world in general—and also an increased appreciation for humor.

• Theresa finds that she has developed increased awareness of her experience beyond her “thinking mind,” including her body and creativity.

• Byron feels his overall experience is “richer and broader” with a greater sense of presence. He also has a sense that his self “is not so solid,” which goes along with feeling more unitive feelings in general.

• Cheryl finds that she now experiences a wider range of feelings, which includes generally more joy, love, and compassion, and less hatred and judgment.

• Jeremy has discovered that the range and depth of feelings available to him has increased significantly.

An increased sense of interconnectedness. All participants expressed experiencing a significantly greater sense of interconnectedness now than they did prior to the onset of the psychosis, generally speaking, and to a greater or lesser degree. As mentioned above, interconnectedness as used here refers to the concept that all manifestations of the universe are fundamentally interconnected.

A strong desire to contribute to the wellbeing of others. All participants expressed a significantly stronger desire to contribute to the wellbeing of others. Trent has been seriously involved in the Big Brothers Big Sisters project, in which adults mentor/befriend troubled youths. All five of the others have become professionally
involved within the mental health care field, each working in some way or another with people suffering from psychosis and other extreme states, and all of them apparently going well beyond the call of duty, striving to make genuine beneficial change in the field.

**Appreciating the limits of consensus reality.** All participants expressed experiencing the limitations of consensus reality, though each in somewhat different ways.

- Sam had profound experiences of “parallel worlds” during his psychosis, and though he has not experienced any psychosis in many years, he continues to maintain some sense of this. Closely related to this is an increased capacity to be aware of and to tolerate paradox.

- Trent has come to see the world as “limitless” and full of possibilities beyond the constraints of consensus reality.

- Theresa has expressed that she has loosened her attachment to her thinking mind. Along with this has come the recognition that there are other equally valid realms of experience, and the importance of recognizing that there is some validity to anyone’s experience of the world.

- Byron has come to see that we all see the world with vision that is distorted significantly by our own conditioning and ignorance regarding the true nature of the world—“everyone is crazy.”

- Cheryl has come to appreciate that there are different valid realms of experience, including those that are not experienced within consensus reality.
Jeremy has come to recognize the frailty of our cognitive constructs—how we all “cobble together little rafts and ride them around” in the face of the “awesomeness of the universe.”

**A greater understanding of psychosis.** All participants expressed having come through their process with a much greater understanding of their psychosis, and even a better understanding of psychosis in general. All participants have come to see their own psychosis as a natural process that resulted from finding themselves in an intolerable situation. All except for Trent now work professionally with people suffering from extreme states and so have the unusual perspective of having been on both sides of the mental health care worker/patient relationship.

- Sam understands his psychosis as having possibly two different causes which are not necessarily mutually exclusive: He believes his psychosis may have come on as a result of the severe stress of being drafted combined with not sleeping, the lack of self care, and possibly the use of recreational drugs; and he also believes there may be some validity to the idea that his “consciousness and corporeal self were jumping between dimensions of the multiverse.” He has also come to appreciate the harms and benefits of the use of antipsychotics in the recovery process, particularly the harm of using them as “long term prophylactics” and the potential benefit of using them in a very judicious manner.

- Trent has come to see his psychosis as an “awakening and a new direction from an ill path from a very young age.”
- Theresa has come to see her psychosis as a healing process of her psyche that allowed her to heal at a very deep level so that she could transcend her isolation and inability to meet her needs and eventually have a healthy family.

- Byron has come to see that “everybody’s crazy” in the sense of being ignorant to the true nature of the world. He sees his own psychosis as the expedited settling of his “karmic debt,” in the sense that it allowed him to work through a lot of his own ignorance and suffering. He has also come to believe in the importance of minimizing psychiatric drugs and forced restraint, and to learn to trust the process, as was done in J. W. Perry’s Diabasis house. He has also come to see that all psychoses have a spiritual component and that attempting to separate spiritual problems from genuine psychosis is ultimately an exercise founded on a false distinction.

- Cheryl has come to see that her psychosis has allowed her to heal at a very deep level—“it ripped off all the layers and got right to the core.” She has also come to see antipsychotics as generally more of a hindrance than a benefit and she is a strong advocate for the “message of hope” for full recovery within the mental health field.

- Jeremy has come to see psychosis in general as “an activity that the psyche has taken up in order to achieve some kind of balance” in the face of overwhelming feelings and experiences. He sees a strong link between isolation and psychosis, and also between the individuation process of a young adult and psychosis. He also has come to greatly appreciate the primacy of healthy relationship in supporting the recovery process.
Lasting Benefits

**Greatly increased wellbeing.** All participants expressed experiencing a significantly greater sense of wellbeing now than they did prior to the onset of the psychosis, generally speaking, and to a greater or lesser degree.

**Greater equanimity.** All participants expressed experiencing significantly greater equanimity now than they did prior to the onset of the psychosis, generally speaking, and to a greater or lesser degree. Equanimity, as I am defining it here, refers to the capacity to maintain a relatively calm and balanced state of mind, even while under stress.

**Greater resilience.** All participants expressed experiencing significantly greater resilience now than they did prior to the onset of the psychosis, generally speaking, and to a greater or lesser degree. Resilience, in contrast to equanimity, refers to one’s ability to return to a relatively calm and balanced state of mind after having lost one’s balance (which they all expressed still occurs at times).

**Healthier relationships with self.** All participants expressed having a healthier relationship with themselves now as compared to prior to the onset of the psychosis, though they each emphasized different aspects of this.
- Sam feels he has developed an increased capacity for self awareness, which includes the ability to identify when he might need support and when to ask for it. He as also gained a greater appreciation of the value of self care, and he feels that his self esteem and confidence have increased significantly.
• Trent feels that his self confidence and courage to be authentic with himself and others has increased. He also expressed having a significantly greater awareness of his needs and the capacity to meet them.

• Theresa finds she has a greater sense of self worth and self acceptance, which is closely related to her decreased need for approval from others.

• Byron expressed having a less solid sense of self, which entails being much more at ease with himself.

• Cheryl feels that she has a more innate sense of self worth, based on who she is, not on what she does. Also, her sense of self love and self forgiveness has greatly improved.

• Jeremy expressed having “far more confidence and assertiveness” now.

**Healthier, more rewarding relationships with others.** All participants expressed that their relationships with others have become far healthier and more rewarding.

• Sam feels he has an increased ability to be supportive of others and an increased capacity to see the humanity of others, both of which contribute to significantly improved relationships.

• Trent expressed that he has “much more intimate and insightful and compassionate and enjoyable” relationships now.

• Theresa finds that, since she experiences much more self worth and less need for approval, she is able be more at ease in relationship now and she finds them much more rewarding.
• Byron feels he has more presence and empathy with others, both of which have improved his ability to listen to and connect with others more deeply.

• Cheryl feels that she had “seeds of hatred” and significant judgment towards others prior to her psychosis. Now that these have faded and she has much more love for herself, she finds that she has much more love and compassion for others.

• Jeremy has come to “cherish the value of human relationship to a far greater degree.” He no longer feels he has to save people, and therefore finds his relationships much more wholesome and easeful—“I don’t have to take other’s pain to be loved.”

**Lasting Harms**

All participants expressed feeling many more benefits than harms overall, though all except Theresa expressed that they still feel some lasting harms.

• Sam feels he still has some unresolved grief and trauma.

• Trent still has some challenges with social stigma. In particular, he finds some challenge holding the tension between his high regard for authenticity and not wanting to be judged harshly by others for having been diagnosed with a “mental illness.”

• Byron says that he can connect with the general sense of being a “wounded healer.” He also has some mild regrets for having missed out on higher education as a result of his “spiritual experiences [being] more compelling.”

• Cheryl describes her psychosis as having been “traumatic,” and she still feels some residue from that, primarily in the form of occasional anxiety.

• Jeremy expressed experiencing a lasting harm that is, ironically, a negative aspect of the benefit of a deeper connection with himself and a sense of purpose. Since he is so
strongly compelled to devote himself to improving the mental health care system, he feels the reduction of alternative possibilities that this entails.
A Generated Theoretical Model:
The Duality/Unity (DU) Model

As discussed previously, my research question is “How have the personal paradigms (i.e., one’s experience and understanding of one’s self and the world) of those who have recovered from long-term psychosis changed throughout the psychotic process, from onset to full recovery?” My hope has been that such an inquiry might provide useful information regarding what takes place during the psychotic process at the most fundamental levels of experience, and that perhaps this information might assist in formulating a more or less universal map that can be of service to other travelers who have descended into psychosis and are still seeking a way out. After collecting the data from the six participants of this study and then analyzing each case individually and then across cases, as presented above, I carried out an extensive process of triangular analysis between the data, other relevant literature in the field, and an emerging theoretical model. I finally arrived at a model that I believe is in very close accord with the data and other relevant research in the field. I will first present this model, which I will refer to simply as the duality/unity (DU) model, and then I will discuss the implications of the data generated in this research, using this model to provide a coherent framework for this discussion.

I am positing the DU model as a tentative model of human experience at the most fundamental existential level. The DU model essentially integrates three preexisting models of human experience at the root experiential level—(a) a dialectic model that has been formulated by various existentially-oriented thinkers over the past 80 years; (b) the model of cognitive constructs that has been formulated by numerous cognitively-oriented thinkers over the past 40 years; and (c) a model of duality and unity formulated as a result
of deep phenomenological inquiry within the Buddhist tradition. The integration of these three models provides us with a useful framework for describing the experience of duality and the experience of the interplay between duality and unity, experiences that are important in capturing the full range of experiences of the participants of this study. I will now discuss each of these categories of experience in turn.

Our Experience of Duality

The research suggests that there are two important components of our experience of duality—one can be described as a dialectic that I will refer to as the self/other dialectic, and the other can be described using the concept of cognitive constructs. I will describe each of these in turn here.

The self/other dialectic. The DU model posits that the existential root of our experience is comprised of a dynamic interplay between our experience of duality and our experience of unity. I refer to that component of our experience most directly related to our experience of duality as the self/other dialectic, which consists essentially of two poles set apart from each other in dialectical tension (see Figure 2). To the best of my knowledge, Rank (1936) was the first to posit this idea in his life-fear/death-fear dialectic. He defined life fear as “the fear of having to live as an isolated individual” (p. 124) and death fear as “the fear of the loss of individuality” (p. 124). In 1977, May posited a similar model, suggesting that the root of all intrapsychic conflict is “the dialectical relation of the individual and his community” (p. 228). In 1980, Yalom posited

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2 It is possible that other models, such as the dialogic formulated by Buber and Tillich, may be successfully substituted for one or more of the models used here to create a useful framework for this data; however, after extensive analysis of the data and the relevant literature, I have found that this particular combination accommodates the data particularly well, providing a suitable framework for the highly diverse array of experiences reported by all participants.
Figure 2. The self/other dialectic.

another variation of this theme, suggesting that human suffering arises from the
dialectical tension between “‘Life anxiety’ [which]…is the price one pays for standing
out, unshielded, from nature” and “‘Death anxiety’ [which] is the toll of fusion” (p. 142).

In 1999, Schneider presented still another variation on this theme, defining the two poles
as constriction and expansion and the fears associated with these as the dread of ultimate
constriction (or obliteration) and the dread of ultimate expansion (or chaos). The
self/other dialectic draws extensively from the concept of the dialectic explored by these
authors; however, I have found it helpful to use different terminology and expand upon it
in different ways in order to best represent the data generated by this research.
From a phenomenological perspective, one way that our experience can be divided is between our experience of self and our experience of other, with other referring simply to everything that we experience apart from ourselves (i.e., other people, other beings, the world in general). We can also see this as the classic dualistic subject/object split. It is likely that most of us find that we generally have the experience of a distinct division between self and other, although it is likely that many of us have subjective experiences in which this division feels somewhat blurred—in which the distinction between self and other is not so distinct. The self/other dialectic represents our subjective experience of these two divisions with the two poles of self and other connected by the axis of rapprochement, which represents our experiential location with regard to the perpetual dynamic tension between the two poles. This dialectical tension results from the opposite forces of the two anxieties associated with the two poles. The anxiety we experience in relation to self is referred to as abandonment anxiety, and the anxiety we experience in relation to other is referred to as engulfment anxiety. Abandonment anxiety corresponds closely to what Rank (1936) referred to as life fear—the fear of isolation and of being cut off from connection, and the corresponding desire for connection. Engulfment anxiety corresponds closely to what Rank referred to as death fear—the fear of losing our sense of self, of being engulfed by too much merger and connection, along with the corresponding desire for autonomy. The overall strength of the dialectical tension within the system is directly related to the strengths of these two opposing anxieties.

At any given moment, depending upon the current conditions, we find that our experience is located somewhere along the axis of rapprochement, usually being
somewhat closer either to the experience of self or to the experience of other, but always being within the experiential fields (and thus anxiety fields) of both of these to a greater or lesser degree. It is important to recognize that this dialectic is dynamic, being affected by ever changing environmental conditions and by ever changing degrees of fear and desire. As our current circumstances take us closer to the self pole, we find that we begin to feel the abandonment anxiety more acutely. Our fear of isolation and loneliness increases, and corresponding to this, our desire for love and connection also increases—thus, we find ourselves being pushed/drawn to change our current conditions in the direction of the other pole. As we approach the other pole, however, we find that we begin to feel the engulfment anxiety more acutely. Our fear of engulfment and of losing our sense of self increases, and corresponding to this, our desire for autonomy and individuation also increases—thus, we find ourselves being pushed/drawn once again in the direction of the self pole. As Rank (1936) articulated, and as May (1977), Yalom (1980), and Schneider (1999) later reiterated, we spend our lives perpetually running towards and/or away from one side or the other, continuously striving to find some tolerable middle ground.

According to this model, our subjective experience at any given moment is determined by essentially three factors: (1) the strength of the abandonment anxiety; (2) the strength of the engulfment anxiety; and (3) our location along the axis of rapprochement. (There actually is a fourth factor related to our experience with unity, but for the sake of clarity, I will postpone discussion of this for now). One of the most important implications of this model is the existence of what I refer to as the window of tolerance, the region along the axis of rapprochement within which the overall degree of
anxiety is tolerable. The size and location of the window of tolerance is determined by the relative and overall strengths of the two types of anxiety. If the abandonment anxiety is stronger than the engulfment anxiety, then the window of tolerance will be skewed towards the other pole (see top of Figure 3); alternately, if the engulfment anxiety is
stronger than abandonment anxiety, then the window of tolerance will be skewed towards the self pole (see bottom of Figure 3). The overall combined strengths of the two types of anxieties determine the size of the window of tolerance (If the combined level of anxiety is relatively low, then one will experience a relatively large window of tolerance and will find the capacity to experience a relatively wider range of experience. If the combined level of anxiety is relatively high, then one will experience a relatively narrow window of tolerance and will find the capacity to tolerate only a relatively narrow range of experience (see Figure 4). The window of tolerance can be relatively dynamic, changing in size and location throughout one’s life, and even from one moment to another and in one relationship to another. According to attachment theory, however, it is likely that due

![Figure 4.](image) The overall combination of the two anxieties determines the width of the window of tolerance.
to conditioning and perhaps innate temperament to some degree, most of us tend to experience a window of tolerance that is relatively stable, typically only changing somewhat gradually throughout our lives (Karen, 1994).

Attachment theory (Karen, 1994) provides a particularly useful framework for understanding the different experiences that result with different variations of the window of tolerance. Attachment is defined as “an affectional bond between individuals characterized by a seeing of closeness or contact and a show of distress upon separation” (Rathus, 2006, p. 218). After over thirty years of substantial research, researchers of attachment have generally arrived at the conclusion that there are essentially only four different attachment styles (although there continues to be some debate regarding possible variations of these)—secure attachment and three different types of insecure attachment. Secure attachment is defined as “a type of attachment characterized by mild distress at leave-takings, seeking nearness to an attachment figure, and being readily soothed by the figure” (Rathus, 2006, p. 219). The three types of insecure attachment styles are avoidant attachment, which is “characterized by the apparent indifference to the leave-takings of and reunions to an attachment figure” (Rathus, 2006, p. 219); anxious attachment (also commonly referred to as ambivalent/resistant attachment), which is “characterized by severe distress at the leave-takings of and ambivalent behavior at reunions with an attachment figure” (Rathus, 2006, p. 219); and disorganized attachment (also commonly referred to as disorganized-disoriented attachment), which is “characterized by dazed and contradictory behaviors toward an attachment figure” (Rathus, 2006, p. 219). These definitions are based on observations of infants; however, it
is generally believed that they apply fairly well to adults as well, although the attachment figure is likely to be a romantic partner rather than a caretaker.

Returning to the self/other dialectic, if someone has developed an avoidant attachment style, then we can say that his or her window of tolerance is skewed in the direction of the self pole (see the top of Figure 3). In other words, they generally experience more engulfment anxiety than abandonment anxiety and are therefore more comfortable on the self side of the axis of rapprochement. Like anyone, these individuals are still within the anxiety fields of both the self and the other poles and certainly still feel the abandonment anxiety with its associated fear or isolation and longing for connection. However, since the engulfment anxiety is stronger, they tend to feel more comfortable with isolation than with intimate connection. If such an individual also has a particularly narrow window of tolerance, they may be particularly susceptible to being overwhelmed by engulfment anxiety and therefore cling onto their sense of self with unusual desperation. This may result in what is referred to within the DSM-IV (APA, 2000b) as schizoid personality disorder. May (1977) suggested that an individual who develops an imbalanced emphasis on this side develops “the anxiety of the defiant and isolated individual” (p. 228).

If someone has developed an anxious attachment style, then their window of tolerance is skewed in the direction of the other pole (see the bottom of Figure 3). In other words, they generally experience more abandonment anxiety than engulfment anxiety and are therefore more comfortable on the other side of the axis of rapprochement. These individuals are still within the fields of both the self and the other poles and certainly still feel the engulfment anxiety with its associated fear of being
engulfed and/or losing one’s sense of self. However, since the abandonment anxiety is stronger for these individuals, they tend to feel particularly uncomfortable with isolation and loneliness. If such an individual also has a particularly narrow window of tolerance, they may be particularly susceptible to being overwhelmed by abandonment anxiety and therefore cling onto relationships with unusual desperation. This may result in what is referred to in the DSM-IV (APA, 2000b) as dependent personality disorder. May (1977) suggested that an individual who develops an imbalanced emphasis on this side develops “the anxiety of the clinging person who cannot live outside of symbiosis” (p. 228).

If someone has developed a disorganized attachment style, then we could say that their window of tolerance is particularly narrow. In other words, both engulfment anxiety and abandonment anxiety are so strong that this person can find very little refuge from either one. Such an individual may be able to create a life strategy that works for some time, but their equilibrium would be very precarious. Any circumstance that increases either abandonment anxiety or engulfment anxiety could easily knock the person out of whatever limited window of tolerance they manage to maintain, at which point they might find themselves oscillating back and forth between the two poles somewhat chaotically (hence the term disorganized) until they manage to regain their precarious equilibrium. Yalom (1980) suggested that such an individual is particularly prone to psychosis, an idea that appears to fit well with the data of this study and which I will explore in more depth later.

When considering attachment styles, it is important to keep in mind that these merely represent a style, not a permanently fixed condition. People can experience significantly different degrees of both types of anxieties from one moment to the next,
depending on a number of factors, including especially the nature of one’s relationship with the particular other. This said, the research within the field of attachment study suggests that by adulthood, people do tend to have established a particular pattern of attachment that is relatively persistent (Karen, 1994).

**Cognitive constructs.** In the DU model, one’s cognitive constructs play a very important role. In the language of cognitive psychology, the term cognitive constructs refers to the particular cognitive framework that each individual develops in order to interpret the sensory data that she or he takes in from the world. According to research in the field, the process whereby we interpret raw sensory input contains two interrelated aspects—*bottom-up processing* and *top-down processing*. Bottom-up processing (also referred to as *data-driven* processing) refers to perception that begins with actual raw sensory information taken in from the environment that is combined in various ways to create a *percept* (Galotti, 2008). Top-down processing (also referred to as *conceptually driven* or *theory-driven* processing) refers to recognizing sensory patterns by beginning with already held expectations, concepts, and/or theories (Galotti, 2008). Our cognitive constructs are essentially these expectations, concepts and/or theories that provide the framework for top-down processing.

Our cognitive constructs, then, play a very important role in allowing us to interpret the raw data that we take in through our senses so that we can navigate through the world. They provide us with the means to interpret the subtleties of the raw sensory experience of the world so that we can distinguish our mother from a stranger, a friend from a foe, edible food from inedible matter, and so on. In other words, survival depends upon the development of our cognitive constructs. However, because they are comprised
of our own expectations and conditioned interpretations, they clearly distort the world and can interfere with our ability to perceive the world accurately. Metaphorically speaking, then, it could be said that we all look at the world through more or less colored lenses. Furthermore, if we mistake the lens of our cognitive constructs for true reality, then we risk becoming dogmatic and inflexible in the face of changing conditions. Taken to its extreme, we would “never be able to perceive anything [we] were not expecting, and [we] would always perceive what we expected to perceive” (Galotti, p. 79).

Therefore, it is clear that learning to have an appropriate balance in this regard is essential for optimal health and functioning (Galotti, 2008; Baar, 1997).

**Our Experience of the Interplay Between Duality and Unity**

The experiences of these participants and of many others within the literature suggest that our phenomenological experience includes not only the dualistic interplay found within the self/other dialectic as discussed above, but that it also includes a dynamic interplay between our experience of duality and our experience of unity. The evidence suggests, however, that in contrast to the self/other dialectic, the interplay between unity and duality is not dialectical in nature—that it does not consist of two diametrically opposed forces creating tension between them. Instead, unity can be seen simply as the transcendence of duality, the fundamental interconnectedness and lack of differentiation that exists beneath the apparent experience of duality. In an attempt to remain true to phenomenological description, then, my use of the term *unity* here refers simply to the condition of *nonduality* (i.e., “not consisting of duality” or “transcendent of duality”) and fundamental interconnectedness (see Figure 5).
When discussing the concepts of duality and unity, many different philosophical systems speculate about whether or not there is some separate realm of absolute unity that exists entirely beyond the realm of duality. From a phenomenological perspective, however, it is debatable whether an experience of absolute unity is possible, just as it is debatable whether an experience of absolute duality is possible. A proper discussion of these and similar issues would require a complex philosophical discourse that would take us beyond the scope of the data generated in this study; it would also arguably weaken the credibility of this model since it would shift its foundation from primarily phenomenological experience to intellectual musings. It suffices to say, then, that most of the experiences of the participants in this study can be adequately captured if we consider them to fall along a spectrum between duality and unity where it is likely that most, if not...
all, of their experiences are comprised of some combination of both dualistic and unitive experiences (the details of these experiences will be discussed in more detail later).

In order to better understand this dynamic interplay between duality and unity and the direct experience of it, it will help to first discuss it within the context of a phenomenological perspective and then to show how research from the field of physics has supported this principle using positivistic (rather than phenomenological) methods of inquiry.

**Raw unconditioned experience—the three marks of existence.** The Buddhist tradition, with its development and cultivation of mindfulness meditation, provides a particularly robust method of phenomenological inquiry into the fundamental layers of our experience. By referring to the findings of a practice contained within the Buddhist tradition, however, there is the risk that some readers may immediately discount these findings as being dogmatic or religious. If we do this, however, we make the serious mistake of discounting one of the most robust forms of phenomenological inquiry into human nature that has ever been established—*mindfulness meditation*.

It is difficult to find an appropriate category in which to place Buddhism. On one hand, it clearly functions as a religion for many people, especially in the sense that it offers a powerful immortality project with which to fend off death anxiety, to use Becker’s (1973, 1975) language. It contains many different lineages, many of which seem to be filled with dogmatic beliefs and rituals, as we can say about any of the other major religions. On the other hand, Buddhism had a very different beginning from that of most other religions in that its founder was a man (Siddhattha Gotama) who acted very much like a scientist. He spent many years in the earnest pursuit of a deeper
understanding of the nature of our suffering in the hopes of finding a way out of it.

According to the Buddhist literature, he did finally succeed in coming out of his suffering and in teaching others how to do the same (after which time his name was changed to the Buddha, meaning the awakened one). Whether or not one believes that Gotama actually managed to succeed in this regard, he clearly succeeded in developing a very powerful method of deep and penetrating inquiry into present phenomenological experience, a method he referred to as Vipassana meditation (Hart, 1987), what is often referred to in contemporary Western society as mindfulness meditation.

While there are different variations of mindfulness meditation, the essential steps are generally the same and are surprisingly simple (though not necessarily easy). First, one develops the capacity to maintain relatively steadfast concentration on a single object (typically using one’s breath as the object of concentration); then, one directs this power of concentration towards the phenomenological experience of one’s being (the experience of one’s mind and body), making a determined effort to maintain penetrating awareness and firm equanimity in the face of whatever arises (Hart, 1987). From a scientific perspective, the fact that such a practice is the very keystone of the Buddhist tradition suggests a very important distinction between Buddhism and other major religions. If we were to put aside the various myths, ceremonies, rituals, beliefs, etc. that we often find within the different divisions of Buddhism, what remains is a tradition spanning over 2,500 years during which time millions of people have practiced this highly disciplined form of phenomenological inquiry; and those who have had the discipline to take this inquiry far enough have arrived at a common experience of three qualities that appear to
lie at the foundation of human phenomenological experience—what are referred to as the three marks of existence.

According to these practitioners, raw unconditioned experience is comprised of essentially three qualities: (a) impermanence—the experience of all manifestations of the world, including the self, being in a state of constant change, constantly fluxing and flowing (known as *anicca* in Pali, the language used in the original Buddhist scriptures); (b) interconnectedness—the experience of all dualistic forms of the world, including the self, being merely different manifestations of a common source (*anatta* in Pali); and (c) the suffering that results, on one hand, from our desire to maintain a solid and permanent self in a world that is so fundamentally impermanent and interconnected, and on the other hand, from the apparent isolation we feel while maintaining this sense of self (*dukkha*; Bodhi, n.d.). We can see that this suffering corresponds very closely to the anxieties found within the self/other dialectic, in which we are perpetually seeking a window of tolerance in which we are not overwhelmed by the fear of engulfment and loss of our sense of self on one hand or the fear of abandonment and/or isolation on the other. In the DU model, then, the suffering associated with dialectical tension is synonymous with the suffering referred to here as one of the three marks of existence (*dukkha*).

There are some teachings within the Buddhist tradition that suggest that there is a unified realm that exists entirely beyond the realm of duality. However, the Buddha himself was quite clear in suggesting that such metaphysical speculation is not helpful and perhaps even harmful in the sense that it risks keeping us mired in intellectual quagmires rather than allowing us to cultivate direct phenomenological experience of being (Thanisarro, 1997). Considering that none of the participants in this study reported
having direct experience of such a realm, and in the spirit of maintaining a strong 
emphasis on phenomenological experience, it is important to clarify that no such 
assertion is being made within this model. What is being asserted, rather, is that our 
cognitive constructs and the dialectic of being within which we find ourselves has the 
tendency to create the illusion of ourselves as solid, fixed, relatively permanent entities 
existing in relationship with other solid, fixed, relatively permanent entities; whereas 
deeper experience reveals that beneath this illusion lies a fundamental impermanence and 
interconnectedness. Since many of us have had little or no direct conscious experience of 
these fundamental qualities of experience, however, I believe it will help to take a brief 
detour away from phenomenological inquiry into the positivistic inquiry of physics in 
order to show that the findings from physics and the findings from the phenomenological 
inquiry of mindfulness meditation have demonstrated significantly converging lines of 
inquiry regarding these fundamental qualities of experience.

Evidence for the interplay between unity and duality in the field of physics.
The *Big Bang* theory (by far the most substantiated theory of the creation of our universe; 
Hawking, 2005) postulates that our universe initially began its life as an infinitely small, 
ininitely dense point, known as a singularity that burst forth initially into a uniform 
dense sea of radiation, eventually coalescing and differentiating into all the myriad 
manifestations that we experience today (including, of course, our very own beings; 
Hawking, 2005; Sawyer, 1999). In other words, the Big Bang theory suggests that all 
dualistic manifestation in our universe initially manifested from a single nondual source 
and have been undergoing continuous change on all levels ever since (I use the 
expression “our universe” here rather than “the universe” because it has been speculated
that there may be many other universes that have also manifested in a similar manner, in
what is known as the *multiverse* theory; Greene, 2003). This theory therefore, then,
provides significant evidence for the principles of fundamental interconnectedness and
impermanence existing at the fabric of our universe, as well as for the principles of unity
and duality.

Einstein’s well established equation, $E=mc^2$, has lent significant validity to the
idea that matter and energy are merely different manifestations of the same fundamental
material of the universe (a concept known as *mass-energy equivalence*; Einstein
1922/2003), a concept that is in accord with the Big Bang theory in indicating profound
interconnectedness within the universe. Research within the field of quantum mechanics
has taken this concept one step further and concluded that not only are matter and energy
comprised of the same fundamental material, but that all such material actually consists
of both matter and energy simultaneously (that light and all subatomic particles are most
accurately understood as being paradoxically both waves and particles; Bohm & Hiley,
1993). This line of research provides still further evidence of a fundamental
interconnectedness within the fabric of our universe.

Perhaps one of the most startling findings further validating the concept of
fundamental interconnectedness has arisen from duplicated experiments that have
determined that by affecting one particle within the universe, another particle in another
part of the universe is immediately affected (Bohm & Hiley, 1993; Goswami, 1993). This
finding may at first glance appear to violate Einstein’s *theory of relativity* (i.e., that
nothing can travel faster than the speed of light), but this is the case only if it is assumed
that some signal is transmitted between the particles. What the evidence suggests,
however, is that the theory of relativity is not violated; rather, there must be some fundamental interconnectivity between the particles that transcends time and space altogether, a principle known as nonlocal interconnectivity (Bohm & Hiley, 1993; Goswami, 1993). Again, we see significant evidence of a fundamental interconnectedness in our universe and the existence of the transcendence of duality (i.e., unity).

While the Big Bang theory provides us with evidence that the dualistic forms within our universe may have arisen from a nondual source on the macrocosmic level, there is other evidence suggesting that a very similar dynamic is taking place much more rapidly on the subatomic level. Research within the field of quantum mechanics has provided evidence suggesting that within the fundamental fabric of the universe (i.e., within all matter/energy and even within the vacuum of apparently empty space), there is a constantly seething activity in which subatomic particles (known as virtual strings or virtual particles) literally manifest from apparent nothingness (an apparently nondual source) as pairs involved in a dialectical relationship (particle/antiparticle pairs), and then apparently annihilate each other (Greene, 2003; Hawking, 2005), disappearing back into the same nondual source from which they came. It is speculated that these pairs of particles continuously manifest and disappear many trillions of times a second. These findings provide us with evidence of profound impermanence and the interplay between duality and unity taking place continuously at the very fabric of our universe.

While it is impressive how far the scientific method, and the field of physics and cosmology in particular, have taken us with regard to a positivistic understanding of the fabric of the universe, there continue to be many unanswered questions and mysteries. For example, it is speculated that there is far more dark matter and/or dark energy than
observable matter and/or energy within our universe (Greene, 2003; Hawking, 2005). The existence of dark matter and dark energy has been postulated to account for significant gravitational patterns in our universe that are difficult to account for by any other means. There is no indication that dark matter is fundamentally any different than observable matter except that it does not participate in the process of nuclear fusion and so cannot be detected with a telescope (Greene, 2003); and it is speculated that dark energy is an as yet undetectable energy that emerged during the earliest stages of the Big Bang and continues to homogeneously permeate our entire universe, playing a role in the accelerated expansion of our universe (Amendola & Tsujikawa, 2010; Hawking, 2005).

These and other such mysteries have continued to add credence to the theory of the Big Bang (Greene, 2003; Hawking, 2005), and therefore the fundamental interconnectedness within our universe that this theory implies. A number of theoretical physicists (including Battista, 1996; Bohm & Hiley, 1993; Goswami, 1993) have taken a particularly strong interest in the concept of fundamental interconnectedness, a concept that has gained significant momentum since the emergence of the field of quantum mechanics. After taken into account the accumulating evidence within the vast field of theoretical physics, they have suggested that the sum total of this evidence points to a new paradigm that is significantly different than the paradigm of strict duality that predates it. Battista (1996) summed up this new paradigm well, referring to it as the holistic paradigm:

Knowledge is conscious, consciousness cannot be separated from matter, consciousness is hierarchically organized, the observer cannot be removed from what is observed, and the world of knowledge is based on quantum-actions, or information events that involve the interaction of parts of one interconnected, conscious universe. (pp. 203-204)
We can see that the findings of the field of physics and of intensive mindfulness meditation practitioners have shown strikingly convergent lines of inquiry in regard to several aspects of the fundamental nature of the universe. In particular, they both generally agree on the idea that the fabric of our experience and of our very being consists of an interconnected, impermanent, and groundless sea comprised of the interplay between unity and duality.

**Transliminal experiences.** Within this model, we can say that the three marks of existence essentially represent the phenomenological experience of the interface between unity and duality without the usual veil of our cognitive constructs with which it is ordinarily covered. To use the language of cognitive psychology, we could say that such an experience of the raw nature of the world consists of a very high degree of bottom-up processing. Clarke (2001), a cognitively-oriented researcher, refers to all types of such experiences as *transliminal experiences* (as in “between realms”).

All such transliminal experiences are generally considered to be quite rare—for most of us, our cognitive constructs do a very good job of ensuring that these kinds of experiences do not happen (Clarke, 2001). However, in unusual circumstances, one’s cognitive constructs may be destabilized and/or weakened, and the possibility of having transliminal experiences is correspondingly increased. This can happen as a result of being under the influence of certain psychoactive substances (especially hallucinogens), during intensive mindfulness meditation (as described above), or during other experiences that significantly challenge the validity of our present cognitive constructs (e.g., a profound epiphany or paradox).
While such unusual circumstances may destabilize and/or weaken anyone’s cognitive constructs, it seems that there are certain individuals who, for yet undetermined reasons, have a particularly unstable set of cognitive constructs that may contribute to an unusually high susceptibility to psychosis. The data generated from this study and other research (Chadwick, 1992, 2001; Clarke, 2001; Frith, 1979; Hemsley, 1998) suggest that transliminal experiences are an important component of psychosis, and in fact, they may even be an essential defining feature of it. Clarke (2001) suggested that, “for the person with psychosis, the barrier that makes this sort of experience hard to access for most of us is dangerously loose” (p. 137). Based upon the results of this study, I believe that the concepts of cognitive constructs and transliminal experiences have particularly important implications for the various stages of psychosis and recovery, implications that will be developed further as the various stages of the psychotic process are discussed in more depth in later sections.

**Maintaining Survival of the Self**

The results of this study suggest that the onset of psychosis is closely associated with experiencing an overwhelming existential threat to the self. The evidence suggests that there are primarily two manners in which such an overwhelming existential threat can occur—either when someone experiences overwhelming dialectical tension as a result of finding oneself outside of one’s window of tolerance, or when someone has a sudden and/or relatively intense experience of unity (i.e., a transliminal experience) while continuing to have relatively strong dialectical tension (i.e., a relatively strong dualistic experience of the self).
**Overwhelming dialectical tension.** In what is probably the most common manner that an overwhelming existential threat to the self occurs, someone experiences an overwhelming degree of dialectical tension when a situation occurs that places them outside of their window of tolerance. As discussed above, this occurs when, due to the circumstances in one’s life, one finds oneself outside of their window of tolerance (or their window of tolerance may have even disappeared altogether in extreme cases). This may take place gradually over many years, or it may take place rather suddenly, within even just a few moments. While such an overwhelming threat is fortunately quite rare, a number of existentially-oriented thinkers have suggested that all of us may continuously grapple with more manageable levels of such existential threats all of the time, even though this struggle may remain primarily unconscious (Becker, 1973; May, 1977; Rank, 1936; Yalom, 1980). It could be said that the role of the abandonment and engulfment anxieties is to warn us of existential threats; therefore, since we exist constantly within the fields of both of these anxieties, we constantly feel some threat to the self to a greater or lesser degree, which is in accord with the work of Becker (1973), May (1977), and Yalom (1980).

Yalom (1980) suggested that there are essentially two strategies that we all use to fend off the fear of death to the self—those who are more comfortable with the self side of the dialectic (to use the terms of the DU model) are likely to cultivate the belief that they are “personally inviolable” (p. 112), which often takes the form of some kind of heroic striving; and those who are more comfortable with the other side of the dialectic, are more likely to cultivate the belief that they are “protected eternally by an ultimate rescuer” (p. 112). Yalom suggested that most of us use some combination of both of
these strategies, and that they both are important in maintaining a relative sense of security in the face of our precarious existence. A problem develops, however, when a significant imbalance develops (i.e., one’s window of tolerance becomes significantly skewed to one side) in that the stronger the imbalance, the more heavily that person is likely to rely upon the strategy associated with that side, and the more extreme that strategy must become in order to be effective (Yalom, 1980).

The implication of this is that these two different strategies create vulnerability to two different kinds of threats to the self, and the more strongly one relies on just one strategy or the other, the more vulnerable one becomes to having that strategy undermined and thereby experiencing an overwhelming existential threat to the self. For those using the strategy of personal inviolability (on the self side), their very sense of self depends upon the maintenance of an inviolable self; therefore, they become more vulnerable to the fear of engulfment and may become overly sensitive to experiencing intimate connection or authority as an existential threat to the self. For those using the strategy of being protected by a powerful other (on the other side), their very sense of self depends upon the maintenance of connection with others; therefore, they become more vulnerable to the fear of abandonment and may become overly sensitive to experiencing any kind of rejection, abandonment, or even diminished contact from others as an existential threat to the self. (This is why I chose to use the term abandonment anxiety rather than isolation anxiety—phenomenologically speaking, the existential threat related to too much movement towards the self pole seems to be that one’s identity as a being-in-connection will be threatened if/when that connection is cut off—i.e., if/when they are abandoned.) For someone who has a more centered window of tolerance, it could be said
that they are less vulnerable to threats from either side, and so are likely to be more successful in staving off significant threats to the self, regardless of the type. Along the same lines, someone with a wider window of tolerance is also clearly more likely to be successful at mitigating threats to the self.

An overwhelming experience of unity. The second way in which one may experience an overwhelming existential threat to the self (and what is probably the least common way) is as the result of a sudden and/or relatively intense experience of unity (i.e., a transliminal experience) while continuing to have relatively strong dialectical tension (i.e., a relatively strong dualistic experience of the self). Such an experience may result in such a severe threat to the self that it may recoil sharply away from unity in the direction of duality, and therefore also ultimately result in an overwhelmingly high degree of dialectical tension (as likely occurred for several of the participants of this study).

If we take a moment to contemplate what it would be like to experience the world in its raw sensory form—as a sensorial experience of an utterly groundless and dynamic sea of dualistic manifestations continuously manifesting from and disappearing into unity—it is not difficult to understand how such an experience can be perceived as a severe threat to the self. As living beings striving to maintain some sense of having a solid and secure self within a solid and secure world, it is difficult to imagine a more severe threat than the experience of the world at this level. Those who have experienced this have often described it as if one’s entire being were disintegrating at the most profound level, a terror perhaps more intense than even the threat of bodily death.
We can also appreciate the severe threat to our sense of self often associated with transliminal experiences from a more practical standpoint. Such experiences correspond to the undermining of our cognitive constructs, and as discussed above, properly functioning cognitive constructs are an essential component of our capacity for discriminatory awareness and our ability to function in the world.

**The psyche’s role in maintaining survival of the self.** One way to conceptualize the psyche is to consider it as the agency of the self and its most fundamental role as the maintenance of the survival of the self. Within the framework of this model, then, I suggest that the fundamental role of the psyche is to maintain the self’s survival by mitigating its existence between unity and duality. On one hand, it must ensure that enough dialectic tension is maintained so that the self does not disintegrate (i.e., the dualistic split is maintained); on the other hand, it must also ensure that the dialectic tension does not become so strong as to result in unbearable suffering. This regulation takes place primarily (or perhaps entirely) by regulating the two anxieties of the self/other dialectic. The psyche must regulate the overall dialectical tension, but it also must maintain relative equilibrium between the self and other poles. As mentioned above, too much imbalance on one side or the other makes the self particularly vulnerable to the existential threats of abandonment and engulfment.

It seems that the psyche deals with threats to the self in several ways. If we find that a situation occurs that has simply put us outside of our window of tolerance (i.e., we find ourselves experiencing an uncomfortable degree of either the abandonment anxiety or the engulfment anxiety), then we typically feel the desire to adjust whatever conditions are necessary to allow us to return to our window of tolerance. If, on the other hand, we
find ourselves unable to make such an adjustment, then our psyche will seek to expand our window of tolerance until we again feel adequate comfort (we typically experience this as spiritual or emotional growth, or maturity). If, however, we find ourselves significantly far outside of our window of tolerance and/or our window of tolerance has disappeared altogether, and we are unable to make either of these adjustments, then the psyche may be forced to resort to initiating a psychotic process involving the destabilization of our cognitive constructs in a desperate attempt to regain a state of equilibrium within our window of tolerance (this will be discussed in more detail later).

A Description of Our Full Spectrum of Feelings

The fundamental qualities of impermanence and interconnectedness (the first two of the three marks of existence discussed above) have profound implications for how we feel the world. In particular, our experience of feeling is dramatically affected by the suffering (the third mark of existence) that we experience as a result of our apparent need to maintain a sense of self in the midst of a world that is so fundamentally impermanent and interconnected. In order to understand more fully how this suffering so profoundly shapes our experience, it will be helpful to again draw from the findings within the Buddhist literature, in which a distinction is made between defilements and unitive experiences.

Defilements and unitive experiences. In the Buddhist literature, the term defilements (kilesa in Pali) essentially refers to all of the feelings we experience as a result of attempting to maintain a sense of self (a sense of duality) in a world in which the fundamental qualities of impermanence and interconnectedness make this so precarious. Within the context of the DU model, then, the defilements are all the feelings directly
associated with the self/other dialectic. As already discussed, we find ourselves perpetually torn between diametrically opposed fears and corresponding desires related to our need to simultaneously maintain a sense of self while also experiencing connection with others. It would seem that the best we can hope for within this dialectical experience, then, is temporary appeasement of the fears and temporary satisfaction of the desires (i.e., the relative ease we feel while residing within our window of tolerance).

From this perspective, then, we can see that all defilements essentially fall within two categories—craving (those associated with desire) and aversion (those associated with fear), although we find that these two categories of defilements give rise to a wide array of feelings (e.g., hatred, animosity, anger, jealousy, envy, fear, terror, lust, greed, longing, sadness, despair, etc.). It is clear to many of us, however, that there is the potential to experience much more than this. Many claim to have experiences of profound joy, liberation, unconditional love, and deep compassion for others. So, where do these kinds of experiences fit in with our experience of duality? According to the findings contained within the Buddhist literature, they do not.

The Buddhist literature suggests that it is only when we begin to relinquish the illusion of duality (i.e., our self as fundamentally separate from the world) that these other more unitive experiences become available to us. The unitive experiences are arguably much less diverse than the defilements. One teaching suggests that all unitive experiences are comprised of essentially four qualities, which are referred to as the four immeasurables—unconditional love, compassion, sympathetic joy, and equanimity (“The Four Immeasurables,” 2006). When we directly experience our interconnectedness with all things, we naturally discover a sense of unconditional love, compassion, and
sympathetic joy for all beings. As the experience of ourself as a fundamentally distinct and separate self fades, the associated anxieties of the dualistic self/other split naturally fade and we discover a profound sense of equanimity. I will refer to these types of feelings hereafter as simply unitive experiences. In this perspective, unitive experiences are considered to be the ultimate ground of our experience since they correspond with an experiential understanding and integration of the most fundamental qualities of experience (i.e., the three marks of existence). They never actually leave us but are merely covered over by the defilements that manifest within the dialectic struggle of duality. From this perspective, then, all of our subjective feelings are comprised of some combination of feelings from both of these categories, as an ever changing mosaic of defilements covers and interacts with the underlying unitive experiences to a greater or lesser degree.

Our experience of good and evil. One particularly interesting implication of this model of our spectrum of feelings is that it provides a relatively simple framework to explain our experiences of good and evil. Most major religions and systems of morality, and I suspect most people in general, would consider the unitive experiences as defined here (unconditional love, compassion, etc.) to be the highest qualities of goodness; and most major religions and systems of morality, and likely most people in general, would agree that if we become overwhelmed by the feelings referred to here as defilements, then we are likely to act in ways that are often considered evil. In other words, if we become overwhelmed by greed, lust, hatred, animosity, despair, fear, etc., then we become much more likely to act in ways that cause harm to ourselves and/or others. In the Buddhist tradition, there is no reference to good and evil in quite the same way as it is
often described in other religions or systems of morality. Rather, there is simply wisdom (dhamma in the language of Pali) and ignorance (mara). Wisdom refers to the experiential understanding and integration of the three marks of existence, and ignorance refers to the lack thereof. These conceptualizations of good and evil are particularly pertinent to the research here in that all of these participants had profound experiences of good and evil, and I have found that this model fits their experiences particularly well (the details of which will be discussed in later sections).

**Terror and euphoria within transliminal experiences.** As discussed above, if we experience the raw nature of the world, there is the likelihood that we will experience profound terror as we experience our sense of self being undermined at the most fundamental level. Yet, the lessening of one’s sense of self provides us with the capacity to experience liberating unitive experiences. How can such apparently similar experiences lead to both feelings of abject terror and feelings of profound liberation and euphoria?

There is a way to explain the propensity for both terror and euphoria within transliminal experiences that is in close accord with the Buddhist literature, research within the field of cognitive psychology that has studied this phenomenon (Clarke, 2001; Frith, 1979; Hemsley, 1998), and the experiences of the participants within this study. As discussed above, if someone happens to have an experience of the raw nature of the world in a particularly powerful or sudden manner while one is still maintaining a strong sense of self, it is likely that they will experience profound terror. In this case, since the individual is still holding onto a strong sense of self (which corresponds to high dialectical tension), such an experience represents an extreme threat to the self. On the
other hand, if the tension within the self/other dialectic is relatively low and/or the transliminal experience is relatively subtle, then one can experience profound euphoric liberation or other unitive feelings as the tension within the self/other dialectic is further diminished and unitive experiences are free to rise into consciousness (what Maslow referred to as *peak-experiences*; 1968). In the latter case, the transliminal and unitive experiences are much more likely to be integrated to some extent, and so may result in a lasting shift in one’s personal paradigm that allows for more unitive experiences in general within one’s life.

**Defining our Personal Paradigm**

If we combine the above understanding of the full spectrum of our feelings with the concept of cognitive constructs discussed above, we now have a relatively complete framework for defining one’s *personal paradigm*, which consists of both one’s personal epistemology (the framework with which one acquires knowledge about the world—i.e., our cognitive constructs) and one’s personal ontology (how one experiences the nature of one’s being—i.e., one’s spectrum of feelings).

**The Optimal Personality**

Before moving on to the implications of the data, there is one final concept that needs to be incorporated into this model in order to adequately address all of the experiences of the participants. Schneider (1999, 2008) posited a dialectical model of human experience that defines the poles as *constriction* and *expansion* and the fears associated with these poles as *the dread of ultimate constriction* and *the dread of ultimate expansion*. In some ways, Schneider’s use of constriction and expansion may have the potential to offer a more penetrating inquiry into the core existential nature of being than
does the use of self and other. However, I have found that the use of self and other creates a more facilitative framework for the phenomenological nature of the data that has been gathered in this research. There is an important component of Schneider’s model, however, that I believe is very helpful to incorporate into the model presented here—the concept of the *optimal personality*.

Schneider (1999, 2008) posited that what defines limitation and dysfunction is our dread of the polarities of our experience, which leads to extreme counter-reaction and the possibility of becoming fixated at one pole or the other (i.e., polarization), what I believe corresponds to the development of particularly skewed windows of tolerance in the context of the self/other dialectic. Schneider (1999) said that what defines our freedom, then, is our ability to *center*, which refers to our capacity to allow our experiences to fall along the entire range of our experience with awareness, resilience, and the confidence that we can survive all of these experiences. Schneider suggested that if we can find the courage and willingness to face our present experience with equanimity, regardless of how painful that might be, we find that it is possible to develop a sense of mastery within our experience. We learn that we can actually develop the ability to return to center, and as our confidence builds in this regard, we find that we can maximally expand the range of our experiences along the continuum. Therefore, being centered does not mean literally remaining fixed within a central position between the dialectic poles of our experience; it means remaining centered in the paradoxical sense of being able to maintain an overall integration of both poles while also maintaining the ability to shift from one extreme to the other. As we develop this capacity, we move ever closer to what Schneider refers to as the optimal personality—we find that our enhanced capacity to
experience a greater range of experiences with attunement leads to an increasingly rich, healthy, and fulfilling life (1999).

Placing the concepts of centering and the optimal personality into the context of the self/other dialectic, then, we can say that as we develop an increasing capacity to center (i.e., to face with equanimity an increasingly wider range of the spectrum of desires and fears associated with our relationship with self and other), we increase our window of tolerance, and this then corresponds with Schneider’s use of the term optimal personality. We find that the range of experiences that are tolerable to us widens, we feel the anxieties of abandonment and engulfment less acutely, and we find that even when we do have experiences that take us out of our window of tolerance, we are able to return relatively quickly. In other words, we find that both our equanimity and our resilience strengthen.

One important implication of this is that as one’s window of tolerance opens in both directions, one’s experience of both poles begins to change—both abandonment anxiety and engulfment anxiety correspondingly diminish. As a result, one is able to experience a richer, fuller, healthier relationship with one’s self and also with others. This may include experiences and feelings such as self connection, self worth, personal power/confidence, autonomy, and a greater ease with aloneness on the self side; and experiences and feelings such as romantic love (Eros), affection, respect, consideration, empathy, and friendship on the other side. Such an individual is more comfortable “in their own skin,” experiencing the appreciation of aloneness more than the despair of loneliness; they are also more comfortable within intimate relationship, enjoying a sense of deep connection with others without the fear of losing oneself. In other words, to use
the language of Gestalt therapy (Perls, Hefferline, & Goodman, 1951), one is able to experience genuine contact with others rather than either isolation or confluence (in which one loses connection with oneself and becomes somewhat lost within the other). In the language of attachment theory, we would call such an individual securely attached to a greater or lesser degree (Karen, 1994).

When we apply the concept of the optimal personality to include the concept of unity and unitive experiences, we find some very interesting implications. As one experiences growth in the direction of an optimal personality, both the abandonment anxiety and the engulfment anxiety diminish, and the defilements within one’s subjective experience correspondingly diminish. As a result of this, the overall dialectical tension is diminished and unitive experiences become more available, offering a depth and richness to the experiences associated with the self/other dialectic and also increasing the full spectrum of available feelings and experiences. As unconditional love, compassion, and sympathetic joy become an increasing part of one’s experience, not only do relationships begin to have greater depth and connection, but one also begins to experience a more profound sense of connection with all (what might be considered spiritual growth). To use Buber’s (1923/1996) language, one begins to experience more I-Thou relationships in contrast to I-It relationships.

In contrast to the individual who experiences terror when their veil of cognitive constructs is suddenly lifted, the movement towards an optimal personality is generally a gradual process, and so the transliminal and unitive experiences have time to be integrated without overwhelming the individual. Such a process may happen so gradually that one never has to experience the sudden undermining of one’s cognitive constructs at
all—during such a process, the cognitive constructs have time to shift gently as new material is integrated. In the field of transpersonal psychology, this could be seen as the process of spiritual emergence in contrast to spiritual emergency (Cortright, 1997).
Implications of the Data

Now that the basic outline of the model that has been generated from this research (the DU model) has been presented, I will use this model as the framework for discussing the implications of the data with regards to the six categories of experience that have been studied in this research—*the onset and deepening of psychosis, description of the anomalous experiences, recovery, lasting personal paradigm shifts, lasting benefits*, and *lasting harms*. As I discuss these implications, I will continue to expand upon the model thus far presented and show how the data and the model mutually support each other.

The Onset of Psychosis

When looking at the themes that have emerged for the category of the onset and deepening of psychosis, we see that perhaps the most important factor that all participants share with regard to the onset and subsequent deepening of psychosis is having experienced an overwhelming existential threat to the self (the first theme listed in Table 7), and it is likely that the remaining themes in this category all essentially played a role in contributing to this existential threat (theme (6), “harm from the psychiatric system,” is somewhat of an exception in that it is a factor in the deepening of psychosis and the hindrance of recovery, not the actual onset).

Recall that, in this model, the most fundamental role of the psyche is to maintain the existence of the self, which it does by regulating the tension within the self/other dialectic. Ordinarily, the psyche seems to have a great capacity to do this (sometimes referred to as *organismic wisdom*, the discussion of which is complex and falls outside the scope of this discussion). However, it seems that there are occasions when this balance is thrown off so radically—the existential threat to the self is so strong—that the
Table 7

Converging Themes and Divergences for The Onset and Deepening of Psychosis.

<table>
<thead>
<tr>
<th>Converging Themes</th>
<th>Divergences</th>
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<tbody>
<tr>
<td>(1) An actual or existential threat to the self just prior to onset</td>
<td>(1) All experienced this.</td>
</tr>
<tr>
<td>(2) Childhood isolation</td>
<td>(2) All participants had a significant amount of isolation in their childhood, but to varying degrees.</td>
</tr>
<tr>
<td>(3) The significant use of recreational drugs prior to onset</td>
<td>(3) All but Cheryl had significant experiences with recreational drugs prior to onset.</td>
</tr>
<tr>
<td>(4) A swing between extreme isolation and extreme connection just prior to onset</td>
<td>(4) All but Sam and Trent had this kind of swing just prior to onset.</td>
</tr>
<tr>
<td>(5) A profound shift in one’s personal paradigm just prior to onset</td>
<td>(5) All but Trent experienced profound shifts in this regard; Trent, however, did increase his marijuana use significantly just prior to onset, which may be closely related.</td>
</tr>
<tr>
<td>(6) Harm from the psychiatric system</td>
<td>(6) All experienced this.</td>
</tr>
</tbody>
</table>

Psyche must resort to the extreme strategy of psychosis in a desperate attempt to regain equilibrium within the self system. Perry (1999) put this rather eloquently when he said, “when a person finds herself in a state of acute distress, in circumstances that have assailed her most sensitive vulnerabilities, her psyche may be stirred into an imperative need to reorganize the self” (p. 21). Before going into the details of how the psyche does this (which I will discuss in the following section, the deepening of psychosis), it will help to first discuss the implications of the data with regard to how one comes to find oneself in such a situation in the first place. To facilitate this, I will present a brief sketch of the onset of psychosis for each participant within the context of the DU model.

**Jeremy.** It appears that Jeremy may have developed a relatively narrow window of tolerance during his childhood as a result of “a lot of trauma” with his family and peers. Referring to Yalom’s (1980) two strategies for fending off the fear of annihilation...
of the self, it appears that Jeremy may have developed both types of strategies somewhat significantly. On one hand, he recalls having strong heroic strivings (in particular, related to being the “savior” of his family), which is closely related to experiencing engulfment anxiety; on the other hand, he recalls having the belief that he (along with the rest of humanity) was protected by some “wise group of people steering us,” which could be seen to be associated with the strategy of “being protected…by an ultimate rescuer” (Yalom, 1980, p. 112). The fact that both of these strategies were relatively prominent suggests that Jeremy experienced both types of anxieties fairly acutely, which of course corresponds to a narrow window of tolerance.

At the age of 20, when Jeremy went to London to pursue academic studies, there is evidence that a series of shifts within his window of tolerance took place that ultimately resulted in psychosis. Perhaps the first major shift took place when he chose to abandon the identity and community he had formed in relation to skateboarding. Suddenly finding himself with the need to craft both a new identity and a new community for himself was likely to have destabilized his cognitive constructs somewhat as he attempted to integrate such a major transition taking place at a core level of his being. Shortly after arriving in London, he had the epiphany that “there was no kind of like wise group of people steering us, and [he] found that to be terrifying.” Very quickly, however, this “terror” changed to opportunity as he realized that he could play the heroic role of making a major contribution to our lost and troubled race. In the context of this model, then, we could say that Jeremy had experienced a significant but not overwhelming existential threat to his self when his belief in an ultimate rescuer was undermined. This also corresponded to his insight into the high degree of conflict going on regularly within
human relationships. He was then able to more or less integrate these, however, which resulted in an expansion and shift in his window of tolerance in the direction of the self pole (i.e., his abandonment anxiety diminished somewhat, and so his engulfment anxiety was now relatively stronger). As would be expected, then, he experienced a corresponding strengthening of his hero strategy.

Shortly after this shift, Jeremy had another personal-paradigm-shifting epiphany when he realized that the interpersonal “battles” that he was observing in others was also taking place within himself to some extent. As soon as he realized this, he experienced a significantly increased sense of peace, and a corresponding increase in his self confidence, his self connection, and his connection with others. We could say that this was a genuine growth experience for him—that his window of tolerance had now expanded in both directions, and that he therefore experienced some movement in the direction of the optimal personality.

The danger in such rapid growth, however, is that Jeremy’s cognitive constructs were now relatively unstable as he attempted to integrate these new feelings, experiences, and understandings. When he returned home for the holidays shortly after this, he was relishing in the experience of much healthier relationships that resulted from this shift, and he was likely also feeling an increase in unitive experiences since his overall dialectical tension had diminished significantly. Unfortunately, while in this relatively fragile state, Jeremy attended a party and smoked some marijuana, which likely further destabilized his cognitive constructs (“[it] sent me through the roof”). Then, while in this very precarious condition with regard to his cognitive constructs, he experienced a profound “shaming,” and a psychotic reaction ensued.
Shame is arguably one of the most painful feelings that we can experience, and it is perhaps one of the feelings most closely associated with very high dialectical tension. With shame, one experiences both types of anxieties very acutely. On one hand, there is the experience that one will be destroyed and/or consumed by others, which is clearly related to engulfment anxiety; on the other hand, there is a very strong fear of being abandoned, of being ostracized and isolated, which is clearly associated with abandonment anxiety. In Jeremy’s case, we can say that just prior to his experience of profound shame, he was attempting to integrate being in the world with a much more diminished dialectical tension than he was used to (i.e., a stronger experience of unity). When the shaming occurred, he suddenly experienced a dramatic swing from relatively strong unity to relatively strong duality. This radical swing represented a severe threat to his self and overwhelmed the precarious balance of his system, throwing him into profound dysregulation at the root existential level and psychosis as his psyche attempted to restore balance (more on this later). What is particularly unfortunate about this situation is that it appears that Jeremy had experienced profound growth immediately prior to this and was in the process of integrating it. Now, after the initiation of psychosis, he would be forced to experience this growth in a particularly haphazard manner.

Theresa. Due to a number of circumstances in her childhood, it is likely that the tension within Theresa’s self/other dialectic became particularly strong, and along with this, it is likely that she developed a window of tolerance on the self side of the self/other dialectic (see the top of Figure 3). She believes this development may have first begun with the birth of her younger sister, after which she experienced the pain of losing a significant degree of connection with her family members as their primary attention
suddenly shifted from her to her sister. As a result of this experience of rejection/abandonment, it is likely that her abandonment anxiety increased initially. She continued to reach towards connection in various ways, but continued to have rejection/abandonment experiences. This occurred each time her parents came back together and then separated again shortly thereafter, and it also occurred to some extent with her peers at school. As a result of this repeated hope for connection followed by devastating disappointment, she lost hope that she would ever be able to satisfy her desire for connection and she lost the capacity to tolerate the pain that connection so often entailed, so she shifted her strategy (and eventually her window of tolerance) towards the self side of the dialectic. She developed a strong strategy of self reliance, and it was likely that this was even further exacerbated by the death of both of her parents and her inability to properly grieve afterwards.

As Theresa shifted her experience towards the self side of the dialectic, she learned to experience herself more as an autonomous being than as one in connection with others. In time, her personal paradigm shifted until she was able to establish some semblance of comfort (window of tolerance) on this side of the dialectic, and her intolerance for intimate connection and fear of being engulfed correspondingly increased. In other words, her abandonment anxiety had become quite strong early in life, but as a result of her developing strategy of self reliance, her engulfment anxiety had eventually become even stronger. As a result, she now found herself with a barely tenable window of tolerance skewed towards the self side of the self/other dialectic. In other words, she continued to have a strong desire for intimate connection, but her fear of engulfment was even stronger.
Having developed a relatively secure foundation on the self side, the threat of engulfment had become a primary threat to Theresa’s self. Too much connection would threaten the loss of her sense as self (as an autonomous, self-reliant being). However, there was still a strong yearning for connection, and when she arrived at the kibbutz, she found this need suddenly and overwhelmingly met. She now found herself in a situation that placed her experience deep into the other side of the self/other dialectic, and far outside of her window of tolerance. On one hand, she found herself relishing the connection for which she had been longing for so many years; on the other hand, she was overwhelmed by engulfment anxiety and resorted to the excessive use of alcohol and hashish as a way to tolerate this:

I was having a great time, you know, but... I practically just wasn’t sober... It was all there but it was too much... it was overwhelming and I couldn’t cope with it, so I had to kind of suppress it the best way that I could.

The alcohol and hashish, however, only provided a temporary coping strategy (as is typically the case with psychoactive substances), and remaining in a situation that placed her so far outside of her window of tolerance did not allow for the possibility of gentle integration (i.e., the gradual opening of her window of tolerance). In time, the alcohol and hashish could no longer contain her anxiety and the tension within the self/other dialectic became overwhelming. Eventually, “... it just kind of bubbled through, you know, and..and just put me over.”

**Sam.** The details of Sam’s childhood are not quite as clear as are those for Jeremy and Theresa; however, he recalls that his parents both struggled with substance abuse and that he was significantly disconnected from them in many ways, especially during his adolescence. It is likely that by the time of his onset into psychosis, he had a
relatively narrow window of tolerance, so was particularly susceptible to overwhelming anxiety and the associated strong threats to his self. He had also been using alcohol and marijuana significantly, and LSD occasionally, since the age of 16, so his cognitive constructs were likely to have already been somewhat unstable.

Upon receiving news that he had been drafted into the Vietnam War, Sam found himself in an untenable existential dilemma. He identified as an anti-war activist at the time—having strong personal values opposed to the war and also having been part of a community that held these values strongly. Now, he found himself torn between the severe threat to his actual physical self on one hand and the existence of his self within his community (friends, family, country, etc.) on the other. It seemed that the only way to avoid going into a situation that presented a severe threat to his physical self and that was in direct opposition to his values was to take the risk to leave and completely abandon his community, which involved a severe existential threat to this self. To use May’s (1977) language, it is likely that Sam found himself experiencing an apparently insoluble dilemma regarding “the dialectical relation of the individual and his community” (p. 228). The dialectical tension became severe, he began to lose sleep, and shortly thereafter, he experienced a psychotic reaction as his window of tolerance had been reduced essentially to nothing. As the result of “conflicts and anxiety which [were] too great for [him] to bear and at the same time [were] insoluble on any other level” (May, 1977, p. 326), Sam retreated into psychosis.

**Trent.** Trent feels that he was raised in a severely dysfunctional family system with his mother having been diagnosed with paranoid schizophrenia and his father having been chronically depressed and emotionally abusive. With apparently dysfunctional
patterns of both enmeshment and severe criticism, it is likely that by the time of the onset of his psychosis, Trent experienced both abandonment and engulfment anxiety quite strongly and his window of tolerance was correspondingly very narrow.

By the age of 24, Trent found his situation truly intolerable. He was still living with his family, his ex-girlfriend and her 2 year old son had just moved in with him as well, and he was forced to take on the role of caretaker in many ways within this dysfunctional system while a part of him was desperately yearning for individuation. He almost certainly would have had a strong desire to move towards autonomy and further development of his sense of self, as is ordinary for someone at that age, yet it is clear that his fear of abandonment/isolation was even stronger and was therefore holding him back. The fact that he remained in such a situation at the age of 24 is indicative of the likelihood that both anxieties were quite strong (with his window of tolerance correspondingly very narrow), yet his window of tolerance was likely skewed to some degree towards the other end of the dialectic (having more abandonment anxiety).

Finding himself in this very difficult situation, Trent began to significantly increase his use of marijuana and tobacco as a way to mitigate the anxiety. Even though these seemed to help reduce the dialectic tension somewhat, at least temporarily, they likely also destabilized his cognitive constructs to some extent (as psychoactive substances are likely to do). In time, Trent’s limited coping strategy failed, and he became overwhelmed by the dialectical tension and the associated reduction of his window of tolerance to essentially nothing. As a result, he soon “imploded into a void where a family was supposed to be.”
Cheryl. As a result of a difficult childhood, having been raised by “immature” parents including a verbally abusive mother and a distant father, Cheryl developed a very painful relationship with herself. She recalls feeling very depressed and harboring strong feelings of self hatred since very early in her childhood and continuing until the onset of her psychosis at age 25. It is likely, then, that she developed a window of tolerance skewed more towards the other pole of the dialectic, finding more comfort being with others than being alone with her despised self. What this meant was that she identified existentially as a being in contact with others and she was therefore particularly vulnerable to experiencing abandonment and/or isolation as a severe threat to her self.

At the age of 25, Cheryl experienced a series of incidents, the effects of each adding onto the effects of the others to carry her ever further into isolation and ever further outside of her window of tolerance, causing significantly heightened dialectical tension and perhaps some associated destabilization of her cognitive constructs. At the same time, she had been practicing some meditation and also eating very little (as a result of a difficult job situation), both of which led to disorientation and perhaps further destabilization of her cognitive constructs. She was clearly in a very fragile state, then, when she attended the spiritual counseling course that was designed to teach her how to contact spirits and other benevolent entities. During this course, she began to hear the voices of disembodied entities whom she initially mistook to be her spirit guides. Initially, they were very benevolent and supportive, saying that they “really cared about [her],” and Cheryl initially experienced genuine relief from her painful loneliness.

Whether or not these “spirit guides” were actually living entities existing in a realm outside of consensus reality, it is clear that this experience provided Cheryl with
some genuine relief from her overwhelming abandonment anxiety. Her dialectical tension would have diminished significantly, and she may have even experienced some unitive experiences, saying that she felt “mild euphoria and liberation” during this time. This experience, however, may have served her in a manner very similar to the way that psychoactive substances served Theresa and Trent—it may have provided some temporary relief from the nearly overwhelming anxiety that she was experiencing but at the expense of destabilizing her cognitive constructs and of being effective for only a short period of time. She remained in a very isolated situation, clearly outside of her usual window of tolerance, so it was not long before her dialectical tension became significantly heightened once again, only now her cognitive constructs had been significantly destabilized.

Cheryl’s cognitive constructs were now open to taking in information in a way with which she was completely unfamiliar—hearing the voices—and she had very few resources for coping with them. (Again, it is not particularly relevant whether or not these voices represented actual spiritual entities or were manifestations of her unconscious mind; phenomenologically speaking, however, they represented a very real experience involving an entirely new method of receiving information.) In effect, then Cheryl experienced a fairly radical shift from isolation and high dialectical tension to intimate connection with the spirit guides and relatively low dialectical tension. This experience was apparently too difficult to integrate, and she found herself swinging back again in the direction of both isolation and high dialectical tension, only now with the voices in tow. In a relatively short period of time, they transformed from being refreshingly benevolent to intolerably malevolence as they began to represent her previous feelings of self hatred,
only in a greatly exaggerated and less manageable form as they relentlessly lashed out at her with unbearably vicious comments. She became completely overwhelmed by this, and a psychotic reaction ensued.

**Byron.** Byron describes himself as having had a “very troubled adolescence” and generally withdrawing from his peers and others. It would appear, then, that Byron experienced a relatively high overall level of dialectical tension with his window of tolerance likely skewed toward the self pole. As he left his house and began the process of individuation, he feels he was fortunate to be a “child of the 60’s,” and before long, he was having very connecting experiences. In particular, he attended the well-known Woodstock music festival and had a profound experience in which he was connecting deeply with other people and also having profound unitive experiences with the aid of hallucinogenic substances. He describes this experience as being incredibly joyful but also very destabilizing, and the onset of his psychosis occurred about six weeks later.

We can imagine that Byron went from experiencing relatively high dialectical tension with an imbalance towards the self pole to very low dialectical tension with the aid of hallucinogens at the Woodstock festival in a relatively short period of time. It does not appear that he experienced a significant recoil response back towards high dialectic tension after experiencing these unitive experiences, so it may be that he was in the process of integrating these in the period that followed. On the other hand, he recalls having felt a very strong desire for transformation after this, and he began to practice shamanic death/rebirth practices in an attempt to bring about such a transformation. Such behavior could be seen as a sign that he was feeling particularly uncomfortable within his present experience, which suggests that he may have been experiencing very high
dialectical tension after his Woodstock experience. If this were the case, it may very well be that he experienced some kind of a recoil reaction to his powerful unitive experiences at Woodstock, yet it was not strong enough to initiate psychosis.

Regardless of whether or not such a recoil response had taken place, what seems clear is that Byron’s cognitive constructs had become unstable as a result of his experience at Woodstock, and one night six weeks later, as he worked diligently to initiate a transformational process, he actually succeeded. Unfortunately, he fell off a three story balcony and landed on his head shortly after completing the shamanic death/rebirth process, so the details of what took place at the moment of onset are somewhat unclear. However, he does have some recollection that his psychotic experiences began before the fall, and then the fall and possibly some minor brain damage may have exacerbated the situation. He did eventually attain full recovery regarding both his psychotic experiences and his cognitive faculties, so any brain damage that he might have received from the fall could not have been particularly extensive, if there was any at all. Regardless of any ambiguity concerning the specific details of the onset of Byron’s psychosis, what seems relatively clear is that it was preceded by the combination of high dialectical tension as a result of his childhood (with a window of tolerance likely skewed towards the self pole) and destabilized cognitive constructs as a result of having both powerful connecting experiences, which were likely well outside of his window of tolerance, and profound unitive experiences.

**The Deepening of Psychosis**

Now that we have some sense as to how the onset occurred for each of the participants, we can explore how the unfolding and deepening of their psychotic process
occurred. It appears that for all six participants there were essentially two common factors that existed prior to and concurrent with the onset of psychosis, as well as during the unfolding and deepening of the psychosis: (a) the instability of their cognitive constructs, and (b) an overwhelming degree of dialectical tension (which is closely related to a severe existential threat to the self, as discussed above).

**The destabilization of one’s cognitive constructs.** Regarding the destabilization of the participants’ cognitive constructs, there is evidence that, for most and perhaps all of them, their cognitive constructs had already been unstable to some degree prior to the onset of psychosis. In Jeremy’s case, it is relatively clear that his cognitive constructs had been quite unstable for some time as he was attempting to integrate profound epiphanies along with the associated changes in his window of tolerance. In Cheryl’s case, it is also clear that her cognitive constructs were relatively unstable as she began to experience the voices of the “spirit guides” before she had a full psychotic reaction. Also, in Byron’s case, it is clear that he was attempting to integrate some profound unitive experiences prior to onset, which would certainly have entailed unstable cognitive constructs. In the cases of Sam, Trent, and Theresa, it is not quite so clear whether or not their cognitive constructs were significantly unstable prior to onset, though they all had been using significant amounts of psychoactive substances prior to onset, which implies that some destabilization was likely present.

Even though it is not clear whether or not all participants’ cognitive constructs were significantly unstable prior to onset, what is quite clear is that, in all cases, the cognitive constructs became unstable as the degree of dialectical tension became overwhelming, a finding that is in close accord with research by Clarke (2001), Jackson
It seems clear that the cognitive constructs play a very important role in this process, and their instability may in fact be a double-edged sword in this regard. On one hand, according to the data and other research (Clarke, 2001), it appears that having unstable cognitive constructs is likely to make one more vulnerable to psychosis. On the other hand, it appears that having unstable cognitive constructs is necessary for significant adjustments to be made on such a profound level within the self (i.e., significant adjustments of the window of tolerance). Regardless of whether or not the cognitive constructs were already unstable prior to the onset of psychosis for these participants, it seems likely that, once psychosis had been initiated, the psyche intentionally destabilized the cognitive constructs as an important component of this desperate strategy to regain equilibrium.

**An overwhelming degree of dialectical tension.** According to the data of this study and other research (Clarke, 2001), it appears that there are primarily two ways that one can experience an overwhelming degree of dialectical tension—either one experiences overwhelming duality (too much dialectical tension) or one experiences overwhelming unity (via an overwhelming transliminal experience). These two different ways actually seem to be very closely related, in that once one experiences one or the other, there appears to be a recoil in the opposite direction, resulting in an oscillation between the two as the psyche attempts to regain equilibrium. The main distinction, then, is simply in regard to which occurred first, and regardless, it appears that the result is very similar—an overwhelming fluctuation between these two states. It seems quite clear that at least five of the six participants of this study experienced overwhelmingly high dialectical tension first, which then led to psychosis and subsequent transliminal
experiences. It is not entirely clear which happened first in Byron’s case—he may have had a transliminal experience first—however, this would still entail an overwhelming degree of dialectical tension in the sense of being overwhelmingly low.

While it seems quite clear that all participants experienced an overwhelming degree of dialectical tension immediately prior to onset, the manner in which this came about was somewhat different for each of them. For Sam, Trent, and Theresa, it seems that there was simply a steady increase in the dialectical tension until the point of overwhelm and subsequent psychotic reaction. It appears that Trent and Theresa (and maybe Sam to some extent) were able to use psychoactive substances to prolong the point of overwhelm, but these strategies ultimately failed and may have even increased the likelihood of a psychotic reaction by allowing them to remain so long in an unsustainable situation and destabilizing their cognitive constructs. The other three participants (Cheryl, Byron, and Jeremy), on the other hand, seem to have experienced a fairly radical swing from very high dialectical tension to relatively low dialectical tension and then back again to high dialectical tension, at which point the psychotic reaction was initiated. One could even argue that this preliminary swing could be considered a very mild form of psychosis, in the sense that some significant dysregulation had clearly begun to take place, although all three of them were still generally in contact with consensus reality at this point. In any event, it is likely that such a swing would make one particularly vulnerable to experiencing a more genuine psychosis.

Seeing psychosis as a desperate attempt to regain equilibrium of the self.

Regardless of whether the psychosis was initiated after a swing between high and low degrees of dialectical tension or was initiated after a gradual increase in the tension until
the point of overwhelm, the essence of what occurred afterwards appears to be relatively similar for all of them. A profound dysregulation of the self occurred, and they began to experience oscillations within their experience on two levels—between unity and duality (between high and low overall dialectical tension), and also between the self and other poles of the self/other dialectic—resulting in the myriad of experiences we associate with psychosis.

These findings are in close accord with the research by Batson and Ventis (1982) and Jackson (2001), in which the evidence suggests that both mystical and psychotic experiences begin with the building of emotional and cognitive tension in relation to an existential problem. Then, upon reaching a particular threshold of tolerance, the psyche attempts to solve this problem, though involving a metaphysical rather than a theoretical paradigm shift. In the context here, I would say that the shift the psyche is attempting to make is simply that of increasing the window of tolerance, which requires a corresponding shift in one’s cognitive constructs. Jackson suggested that there is essentially just one key difference between mystical experiences and psychotic experiences. Mystical experiences lead to the successful completion of a personal paradigm shift that allows for a solution to the problem and the subsequent diminishment of the tension (i.e., the reduction of dialectical tension within the context here); whereas in psychosis, a personal paradigm shift takes place, but this does not resolve the tension and may even generate more tension followed by further paradigm shifts. The result can be a relatively rapid alternation and fluctuation between different belief systems and experiences, a condition we often equate with florid psychosis.
To place these findings within the context of the DU model, we can say that, in psychosis, one’s being is essentially in severe dysregulation as the psyche tries desperately to regain equilibrium after experiencing an overwhelming threat to the self. The cognitive constructs are unstable and there is dysregulation on two levels: between the two poles of the self/other dialectic and also within the overall dialectical tension (i.e., between duality and unity). As a result, the individual in psychosis may experience dramatic oscillations between the strengths of the abandonment anxiety and the engulfment anxiety, as well as an overarching oscillation between a strong and a weak sense of the dualistic split.

**Description of the Anomalous Experiences**

After the psychosis was initiated, the scope and intensity of the anomalous and psychotic experiences that these participants went through is somewhat breathtaking. In spite of this diversity, however, the data reveal that there are actually only a small number of different core themes within these experiences, of which there was surprisingly low divergence between the participants (See Table 8). Both the nature of the converging themes and the low degree of divergence suggest that a very similar process was taking place within all of these participants, and I have found that the DU model provides an effective framework for explaining these experiences.

**Good/evil and creation/destruction.** All participants had polarized experiences of good and evil and of creative and destructive forces. I suspect that these are essentially different manifestations of the experience of unity and duality at the root experiential level. According to this model, these participants all experienced oscillations, to a greater or lesser degree, between very high dialectic tension (a strong sense of duality) and very
### Table 8

**Converging Themes and Divergences for Description of the Anomalous Experiences**

<table>
<thead>
<tr>
<th>Converging Themes</th>
<th>Divergences</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Polarized experiences of good and evil</td>
<td>(1) All experienced this.</td>
</tr>
<tr>
<td>(2) Creative and destructive forces</td>
<td>(2) All experienced this.</td>
</tr>
<tr>
<td>(3) Fluctuating between omnipotence and powerlessness</td>
<td>(3) All experienced this.</td>
</tr>
<tr>
<td>(4) Heroic striving (fighting evil and/or ignorance)</td>
<td>(4) Trent and Cheryl experienced striving against evil forces within themselves; and all except for Cheryl experienced striving against evil and/or suffering &quot;out in the world.&quot;</td>
</tr>
<tr>
<td>(5) Being watched over by malevolent and/or benevolent entities</td>
<td>(5) All experienced this; however, Jeremy was the only one who did not experience both types (experiencing primarily malevolent watching over).</td>
</tr>
<tr>
<td>(6) Groundlessness</td>
<td>(6) All except Sam mentioned experiencing profound groundlessness.</td>
</tr>
<tr>
<td>(7) Parallel dimensions</td>
<td>(7) All but Trent experienced different realms of experience occurring simultaneously to some degree.</td>
</tr>
<tr>
<td>(8) Feelings of euphoria, liberation, and/or interconnectedness</td>
<td>(8) All but Sam recalled having these kinds of experiences, to a significantly greater or lesser degree. Jeremy had these just prior to his psychosis, but not so much after onset.</td>
</tr>
</tbody>
</table>

Low dialectic tension (a strong sense of unity). Recall that with very high dialectic tension, and the corresponding experience of an extreme dualistic split, the defilements (the fears and desires associated with the dialectic poles) are particularly strong, and when taken to their extreme, the defilements correspond closely with feelings we often associate with evil (greed, lust, hatred, animosity, envy, etc.). With very low dialectic tension, there is less of a sense of duality to cover up the unitive experiences (unconditional love, compassion, interconnectedness, sympathetic joy, etc.), which are
closely correlated with the concept of good, so these are much more free to come through into our consciousness.

A person in psychosis is also likely to be significantly exposed to the raw experience of the transliminal realm, the realm between unity and duality, and this realm is seething with creative and destructive forces. From unity arises all dualistic manifestations, the ultimate creative act and once in duality, all manifestations are doomed to undergo decay and destruction. Perhaps one way to distinguish experiences of good and evil from experiences of creation and destruction is that experiences of good and evil represent feelings associated with the extremes of unity and duality, whereas experiences of creation and destruction represent volition associated with these two extremes (although phenomenologically, feeling and volition are typically very closely intertwined). So, as someone in psychosis essentially swings between these unitive and dualistic extremes, they become exposed to a much wider spectrum of feelings, volitions, and experiences than what one would ordinarily experience, and they are also likely to experience these in a much rawer, archetypal form.

**Heroic striving and being watched over.** All participants had experiences of heroic striving and experiences of being watched over by benevolent and/or malevolent forces. All of them also experienced fluctuations, to a greater or lesser degree, between feelings of omnipotence and/or omniscience and feelings of powerlessness. I suspect that these are all closely related, and that they all result from dramatic fluctuations within the two anxieties of the self/other dialectic.

As discussed above, Yalom (1980) contended all of us use essentially two types of strategies to fend of our existential fear of death—(a) the belief that we are “personally
inviolable” (p. 112), which in the DU model corresponds with the self pole, and/or (b) the belief that we are “protected eternally by an ultimate rescuer” (p. 112), which corresponds with the other pole. For a relatively healthy individual, it is likely that both of these strategies will be used to some extent and that they both will take relatively mild forms. For an individual who is experiencing a high degree of imbalance between the abandonment and engulfment anxieties, however, it is likely that they will rely more heavily on just one of these strategies, and that it will manifest in a particularly extreme form. Those with particularly strong engulfment anxiety will likely experience themselves as being somewhat special, and they will likely experience strong heroic strivings. Those with particularly strong abandonment anxiety will likely experience a strong sense of being watched over by a supreme immortal other.

When we place Yalom’s (1980) model of strategies within the context of the DU model, we find a particularly cogent explanation for the experiences of the participants in this regard. In the highly dysregulated state of psychosis, one’s abandonment and engulfment anxieties are likely to be fluctuating dramatically, and as this occurs, we would expect dramatic fluctuations in the strategies corresponding to each type of anxiety. As the engulfment anxiety becomes particularly intense, we would expect the individual to resort to extreme heroic strivings and even feelings of omniscience and/or omnipotence. As the abandonment anxiety becomes particularly intense, we would expect that the individual would experience strong feelings of being watched over by a powerful other. When we keep in mind that these individuals are also experiencing strong fluctuations within the duality/unity spectrum, we can understand why experiences of archetypal good and evil and also creation and destruction tend become so bound up
within these experiences. Heroic striving may become the striving against evil and/or ignorance in the world (as they all experienced to some extent) or the striving against evil within oneself (as was the case for Trent and Cheryl); and one may experience a fluctuation of being watched over by benevolent and malevolent entities (all except for Jeremy experienced being watched over by both types of entities—Jeremy experienced primarily a malevolent watching over).

It is important to note that while all participants seem to have experienced both types of strategies to some extent, there appears to be a high correlation between the type of strategy that was most prevalent for each participant during their psychosis and the direction to which their window of tolerance was likely skewed prior to onset. In the cases of Sam, Jeremy, Byron, and Theresa, it appears that their window of tolerance was likely skewed towards the self pole prior to onset, and as would be expected, they all experienced significantly more heroic striving than being watched over. In Cheryl’s and Trent’s cases, it appears that their windows of tolerance were likely skewed towards the other pole prior to onset, and as would be expected, they both experienced significantly more being watched over than heroic striving.

**Parallel dimensions.** All but Trent recalled having had distinct experiences of different realms of experience occurring simultaneously, although the intensity of this varied significantly between participants. I suspect that this is closely related to the experience of unstable cognitive constructs. Perhaps these participants were aware of multiple sets of cognitive constructs or at least multiple aspects of their cognitive constructs, occurring simultaneously. It is interesting to note that all participants
expressed that one lasting personal paradigm shift has been coming to see the limitations of their construction of reality (discussed in more detail later).

**Groundlessness.** All except for Sam mentioned having experiences of profound groundlessness. According to the descriptions of these participants and the discussion above in this regard, it is likely that their feeling of groundlessness correspond closely to experiencing the rawer nature of the world when one’s cognitive constructs have been significantly destabilized (i.e., the transliminal realm). It is clear that all participants experienced a profound destabilization of their cognitive constructs, so it is somewhat unclear why Sam does not recall having experiences of groundlessness. I suspect that Sam’s cognitive constructs may have shifted quickly enough each time that these rawer transliminal experiences were not made conscious.

**Feelings of euphoria, liberation, and interconnectedness.** Sam, Trent, Theresa, Byron, and Cheryl expressed having experiences of euphoria, liberation, and/or interconnectedness to a greater or lesser degree during their psychosis, and Byron also had such experiences prior to his psychosis. Jeremy experienced these kinds of experiences just prior to the onset of their psychosis, but not so much during his psychosis. According to the DU model, these kinds of experiences likely correspond to the unitive experiences that are free to arise when the dialectical tension has been significantly reduced. It appears, then, that Byron and Jeremy experienced significantly low dialectical tension at times prior to onset and that all but Jeremy experienced significantly low dialectical tension at times during psychosis. According to other aspects of Jeremy’s experience as discussed above, it is likely that he did experience significant
fluctuation between relatively high and low dialectical tension during his psychosis, but that it merely did not reach levels as low as the others during this stage.

The diverse array of other anomalous and extreme experiences. Regarding the myriad other minor details found within these participants’ anomalous experiences, Perry (1999) suggested that individuals within psychosis tend to *identify with* (to associate with the self) and/or *project* onto the world (to associate with others) the experiences that they are having at this root existential level, an idea that appears to fit very well with the data here. It is clear that all participants significantly identified with and projected numerous experiences such as good, evil, creation, destruction, and many others.

Schneider (2008) presented another useful model in this regard, when he suggested that our experience can be divided into six different levels (or domains) of consciousness, all of which are highly interrelated: physiological, environmental, cognitive, psychosexual, interpersonal, and experiential (which corresponds to my use of *existential* here). Each level represents a deeper domain, with the physiological level residing at the surface and the experiential level residing at our core. If we consider that one important role of our cognitive constructs is to maintain some coherence and balance between these different realms, then we can see that having unstable cognitive constructs combined with a highly dysregulated self system can open the door for our past and present experiences related to all of these different realms to come flooding into our consciousness, which is what apparently occurred to a greater or lesser degree at different times for all of these participants.
Recovery

**Seeing full recovery as the successful reorganization of the self.** If we consider that psychosis is essentially a process initiated by the psyche in an attempt to regain regulation of the self system after experiencing an overwhelming existential threat to the self, then we can see recovery as movement toward the regaining of that equilibrium. *Full recovery*, then, would refer to having attained a level of equilibrium that is at or greater than the level of equilibrium that existed prior to the onset of psychosis. In the context of this model, such an overwhelming existential threat to the self is associated with very high dialectical tension and the corresponding reduction of one’s window of tolerance to essentially nothing. Therefore, in order to have any hope of regaining equilibrium, the psyche must find some way to increase the window of tolerance, which is also likely to include a centering of the window of tolerance to a more sustainable and balanced position. To use Schneider’s terminology (1999), we could say that at the onset of psychosis, the self has come to be in a configuration that is diametrically opposite to that of the optimal personality; that during recovery, the psyche is in the process of attempting to reorganize the self at the root-most level of our experience; and upon full recovery, the psyche has succeeded in bringing the self into a new configuration that is much more in alignment with the optimal personality.

**The role of unstable cognitive constructs in profound healing.** In order to carry out such a profound reorganization of the self, it seems that one of the most important resources available to the psyche is the ability to destabilize the cognitive constructs. There is some evidence for this within the field of psychotherapy research. Hallucinogenic substances (such as LSD, peyote, or psilocybin mushrooms) are well
known for their ability to destabilize one’s cognitive constructs, and there is evidence that, when used carefully and with appropriate guidance, they offer the potential for healing at very profound levels (Grof, 2001). All of the participants in this study have also apparently experienced profound healing as a result of the successful resolution of their psychotic process, so the evidence does seem to suggest that the destabilization of their cognitive constructs may very well have played an important role in allowing this healing to take place at this most profound level. Cheryl articulated this well when she said, “the psychotic experience really just like…ripped off all the layers and got right to the core…and then, you know, when I was able to look at my core of self hatred and heal that, then I just..I built my mental health on that from here.”

So, in essence, we could say that the psyche first destabilizes the cognitive constructs in order to facilitate this healing and growth (i.e., the modification of the window of tolerance), and then the cognitive constructs must go through a process of integrating this new way of being and understanding and eventually regain relative stability in this new configuration. We can see that the data presented so far demonstrates that this explanation corresponds well with the experiences of these participants. As we look more closely at the themes regarding what best supported these participants’ recovery (see Table 9), we see continuing evidence that such a natural process was taking place.

**The importance of supporting the process.** When we see psychosis as a natural process, it stands to reason that the most helpful support we can offer to people in recovery is to directly support this process rather than to interfere with it. The major themes that emerged for this category show striking convergence, with all six participants
Table 9

Converging Themes and Divergences for Factors that Supported Recovery

<table>
<thead>
<tr>
<th>Converging Themes</th>
<th>Divergences</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Finding meaning</td>
<td>(1) All experienced this.</td>
</tr>
<tr>
<td>(2) Finding hope</td>
<td>(2) All experienced this.</td>
</tr>
<tr>
<td>(3) Finding self-connection/agency</td>
<td>Meaning and hope seem closely related.</td>
</tr>
<tr>
<td>(4) Healthy vs. unhealthy relationships</td>
<td>Everyone but Sam expressed that making meaning of their experiences gave them hope.</td>
</tr>
<tr>
<td></td>
<td>(3) All experienced this.</td>
</tr>
<tr>
<td></td>
<td>(4) All experienced this. Trent and Jeremy also expressed the importance of distancing themselves from unhealthy relationships, and Byron was well into recovery before connecting with a particularly health relationship.</td>
</tr>
</tbody>
</table>

expressing that all four of the factors listed in Table 9 were important in their recovery.

As we look more closely at the details for each of them, we can see that all of these themes are in direct alignment with supporting the process rather than interfering with it.

The triad of meaning, hope, and self-connection/agency. The first three factors listed in Table 9—hope, meaning, and self-connection/agency—seem to have worked together in a particularly symbiotic manner for all participants. In the face of the intense pain, confusion, and other challenges that all of these participants faced in their process, hope provided the motivation to go on, meaning provided the guidance, and self-connection and agency provided the fuel. These three factors were apparently essential for all six participants in their path towards recovery, and yet all participants found an enormous hindrance to all of these coming from the mental health care system of all places, and particularly from psychiatry.
Psychiatry is the field of mental health that is typically considered to hold the position of highest authority with regard to treating those suffering from psychosis within Western society. Unfortunately, as discussed in detail in the “Literature Review” section, psychiatry has a paradigm of care that is in direct contradiction to the philosophy of supporting the process of psychosis, instead doing virtually everything in its power to try to stop this process in its tracks. Based on the model presented here, one would expect that such a paradigm of care would be more of a hindrance to recovery than a benefit, and this is, in fact, what every participant in this study expressed (although to a significantly greater or lesser degree). Looking again at the factors of hope, meaning, and self-connection/agency, we can see how the mental health care system interfered with all of these.

In particular, it seems that the most harmful aspect of psychiatric care for these participants was the inculcation of the message that they were suffering from a lifelong degenerative brain disease and that they would have to remain on debilitating and highly toxic drugs for the rest of their lives (in spite of significant evidence to the contrary—see the “Literature Review” section). For all of these participants, learning to find hope for full recovery and a fulfilling life in the face of this message of hopelessness was very difficult yet very important to their recovery. One aspect of this that was clearly a hindrance for most if not all of these participants was that they began to fear and mistrust their own mind. If we see psychosis as a natural though precarious process that is initiated by our mind (our psyche), there is no doubt that the mistrust and fear of one’s mind can lead to greatly increased internal conflicts as one becomes involved in an intrapsychic struggle against the very process of healing that is attempting to take place.
While it is of course helpful to have some healthy mistrust for our cognitive constructs (our understanding and interpretation of the world), especially while going through psychosis, it is an altogether different and potentially much more harmful matter to mistrust the nature of the mind itself.

It is also clear that the psychiatric treatment that all participants received undermined their ability to find meaning. For all of these participants, being able to connect with a meaning and a purpose that made their life worth living was very important in their recovery, but in order to do so, they found themselves face to face with the myth of hopelessness proselytized within the psychiatric system. For all participants, finding meaning was two-fold: (a) coming to an understanding of their experiences that was different and more hopeful than the brain disease model given to them by psychiatry, which included their coming to see psychosis as a natural process; and (b) connecting with a meaningful pursuit towards which to channel their passion and energy.

Finally, it is clear that, for all six participants, the psychiatric treatment they received interfered significantly with their ability to connect with themselves and their sense of agency. All participants reported receiving antipsychotics (and other psychiatric drugs) in a manner that was excessive, haphazard, and/or lasting significantly longer than necessary. Another term for antipsychotics, perhaps one that is more accurate, is major tranquilizers, and it is clear that there are few methods more successful at interfering with one’s self-connection and sense of agency than the excessive and/or haphazard use of major tranquilizers. All participants except Trent expressed that the use of antipsychotics was more harmful than beneficial in their recovery. Trent also experienced significant harm from them, especially including one or more relapses of psychosis upon sudden
withdrawal, but he was fortunate to be able to use them judiciously for the most part (typically for just a few months at a time as and when he felt they were helpful).

While most participants considered the primary resources offered by psychiatry (psychiatric drugs and hospitalization) generally more harmful than helpful in their recovery, four of the participants (Sam, Trent, Theresa, and Jeremy) found psychotherapy to be particularly helpful. Trent, however, was the only one who received helpful psychotherapy within the psychiatric system—the others had to seek helpful psychotherapy from private practitioners outside the system.

**Healthy vs. unhealthy relationships.** All participants expressed the importance of cultivating healthy, supportive relationships with others, and Jeremy and Trent also expressed the importance of distancing themselves, at least to some degree, from unhealthy relationships within their family. This finding fits very well with the DU model. It is, after all, unhealthy relationships that typically create skewed and/or narrow windows of tolerance in the first place. If the psyche is attempting to reorganize this window of tolerance, then it stands to reason that distancing oneself from relationships that contributed to this dysfunctional configuration is important. Along these same lines, all participants expressed that healing unhealthy relationships (as was the case especially for Cheryl and Jeremy) and cultivating new healthy relationships (as was the case for all of them) was very important in their recovery. Returning to the DU model, we can say that a healthy relationship involves the paradoxical incorporation of both self and other, the capacity to be relatively comfortable and connected with self and also relatively comfortable and connected with others. Since, in psychosis, it appears that this is exactly
the configuration that the psyche is working towards, it stands to reason that having relationships that support this process would be very helpful.

**Lasting Personal Paradigm Shifts**

All participants expressed that they experience a significantly different personal paradigm now than prior to their psychosis, and the convergence in this regard is striking. All six participants experienced every major theme within this category, to a greater or lesser degree (see Table 10).

**An increased window of tolerance and reduced dialectical tension.** All of the personal paradigm shifts that the participants reported experiencing fit well within the DU model. I suspect that the first four factors listed in Table 10—a significantly changed spectrum of feelings with more depth and more unitive feelings, an increased experience of interconnectedness, a strong desire to contribute to the wellbeing of others, and an integration of good and evil—are very closely related in that they all suggest an overall reduced dialectical tension and an expanded and more centered window of tolerance.

<table>
<thead>
<tr>
<th>Converging Themes</th>
<th>Divergences</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) A significantly changed spectrum of feelings with more depth and unitive feelings</td>
<td>(1) All experience this.</td>
</tr>
<tr>
<td>(2) An increased experience of interconnectedness</td>
<td>(2) All experience this.</td>
</tr>
<tr>
<td>(3) A strong desire to contribute to the wellbeing of others</td>
<td>(3) All experience this</td>
</tr>
<tr>
<td>(4) An integration of good and evil</td>
<td>(4) All experience this.</td>
</tr>
<tr>
<td>(5) Appreciating the limits of consensus reality</td>
<td>(5) All experience this.</td>
</tr>
<tr>
<td>(6) A greater understanding of psychosis</td>
<td>(6) All experience this.</td>
</tr>
</tbody>
</table>
According to this model, when the dialectical tension is reduced, more unitive experiences are available. Also, while the extreme forms of the defilements associated with high dialectical tension (hatred, animosity, greed, envy, etc.) are most likely reduced along with the reduction in the dialectical tension, the feelings that do remain are likely to be imbued with an increasing sense of depth and richness as a result of being more intertwined with unitive experiences. The shift in the spectrum of feelings that all participants expressed is in very close accord with this explanation. While the details of the change in the spectrum of experiences varied somewhat across participants, they all described experiencing more unitive feelings and less of the more extreme negative feelings (i.e., the defilements associated with a very high level of dialectical tension).

All participants expressed feeling a sense of interconnectedness, which, based on the way that it was expressed by these participants, refers to the experience that all manifestations of the universe are fundamentally interconnected. This is clearly a unitive experience and is in contrast to feeling connected with others, which may or may not include a sense of interconnectedness.

All participants expressed feeling a strong desire to contribute to the wellbeing in others, and currently they are all actively doing this in some way. Jeremy was somewhat an exception to the others in that he expressed that the overall strength of his desire to contribute to others had not changed much; however, he said that the reason for this was that, prior to his psychosis, he had a strong sense that it was his duty to save others. What has changed is that he experiences his desire to contribute in a much more balanced way now, remaining much more connected to himself and his own needs now, and feeling that he is acting more from a sense of choice rather than duty. The desire to contribute in this
way is clearly related to unitive experiences, and again, it suggests that the dialectical tension has diminished significantly for all of them.

One would also expect an integration of the experiences of good and evil as the dialectical tension decreases and more unitive experiences are available. While each participant described their new understanding of good and evil somewhat differently, it is clear that they all moved towards a paradigm that is more inclusive, compassionate, and understanding for all, generally seeing evil as associated with some form of ignorance or woundedness, rather than something that is innate within anyone.

**More flexible cognitive constructs.** All participants expressed that they now are much more aware of the limits of consensus reality. We might say that their cognitive constructs have become more flexible, which I suspect is closely related to having gone through an experience in which their former cognitive constructs were so profoundly reorganized. I also suspect that having more flexible cognitive constructs may offer more capacity for growth and resilience (more on this in the next section), a concept that is closely related to Schneider’s term, *fluid center*, which refers to what he believes is a particularly important characteristic found within a healthy individual (2004). There is likely an important balance in this regard, however, since excessive flexibility may make one susceptible to having further overwhelming transliminal experiences, which may then lead to further psychotic episodes.

**A greater understanding of psychosis.** In some ways, it seems a given that all of these participants emerged from their psychotic process with a greater understanding of psychosis. What is particularly interesting, however, is that there are significant parallels in their understanding, and given their unusual wisdom in this regard, it seems
that the mental health care field would do well to pay close attention to these: (a) all participants have emerged with the strong sense that their psychosis was a natural response to finding themselves in an untenable situation (and clearly was not a degenerative brain disease); (b) all participants have come to believe that if antipsychotics should be used at all, they should be used minimally and in a very judicious manner; and (c) all participants have come to believe that their psychosis has resulted in profound healing and far more lasting benefits than harms.

**Lasting Benefits and Harms**

As just mentioned, all participants expressed experiencing far more lasting benefits than lasting harms. Again, as with most of the other categories, the parallels in their experiences in this regard are very strong. There were no significant divergences with regard to the major themes for the category of lasting benefits (see Table 11). All

Table 11

*Converging Themes and Divergences for Lasting Harms and Benefits*

<table>
<thead>
<tr>
<th>Lasting Benefits</th>
<th>Converging Themes</th>
<th>Divergences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1) Greatly increased wellbeing</td>
<td>(1) All experienced this.</td>
</tr>
<tr>
<td></td>
<td>(2) Greater equanimity</td>
<td>(2) All experienced this.</td>
</tr>
<tr>
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<td>(3) Greater resilience</td>
<td>(3) All experienced this.</td>
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<td>(4) Healthier relationship with oneself</td>
<td>(4) All experienced this.</td>
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<td>(5) Healthier, more rewarding relationships with others</td>
<td>(5) All experienced this.</td>
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| Lasting Harms     | (1) (Each participant expressed a significantly different harm) | (1) All except Theresa expressed some lasting harm, though they all expressed experiencing much more benefit than harm overall. |
participants expressed experiencing a greatly increased overall sense of wellbeing and ability to meet their needs, greater equanimity, greater resilience, and healthier relationships with themselves and with others. I believe that the DU model provides an effective explanation for these changes.

As discussed above, the successful resolution of psychosis necessarily entails some degree of widening of one’s window of tolerance and possibly some centering of it, as well as an overall reduction of the dialectical tension. After all, based on what we have seen here, these participants likely experienced psychosis in the first place because they found themselves with a window of tolerance that was insufficient to cope with their circumstances at the time. Therefore, as the window of tolerance was increased and the dialectical tension reduced, we would expect to see an overall increased sense of wellbeing. Regarding the increase in equanimity that all participants expressed experiencing (equanimity being defined as the capacity to maintain a balanced mind in the midst of challenging circumstances), this can also be explained by their having a wider window of tolerance. With a wider window of tolerance, by definition, one can tolerate a wider range of feelings and experiences.

Regarding the participants’ increase in resilience (defined as the capacity to return to the balance of one’s mind after having lost balance), I believe that this may also be a result, to some extent, of having a wider window of tolerance. However, I believe that the increased flexibility of their cognitive constructs may be a stronger contributing factor. After having gone through such a profound reorganization of one’s cognitive constructs, it stands to reason that one is likely to have more awareness of the limitations of them (as indeed they all expressed) and that one would not cling to them so firmly. The natural
result of this, it seems, would be a greater capacity to honor multiple perspectives and to shift one’s own perspective as necessary. To put this in the context of the DU model, we could say that, for those who have relatively more flexible cognitive constructs, it is relatively easier for them to make modifications to their window or tolerance when finding themselves in a situation that places them outside of it. In other words, we would expect them to have greater resilience. Of course, as mentioned above, there is a balance here, since if someone’s cognitive constructs are too flexible, they may be more susceptible to overwhelming transliminal experiences and potentially further episodes of psychosis.

Regarding the participants’ movement towards healthier relationships with themselves and with others, we can also see this as a direct result of their increased window of tolerance. As discussed above, this widening of the window of tolerance corresponds with growth in the direction of the optimal personality and a greater capacity to paradoxically incorporate both a healthy connection with the self and a healthy connection with others, making for much more fulfilling and rewarding relationships.

Regarding lasting harms, four of the participants named just one harm, one participant (Byron) named two harms, and one participant (Theresa) said she could not think of any lasting harms at all. All harms named were described as either being relatively minor or a necessary cost of the benefits that they experienced. Cheryl and Sam still feel some occasional minor anxiety that they feel is in some way related to their psychosis; Trent expressed his challenge with the social stigma of being labeled mentally ill; and Byron and Jeremy both expressed some regrets for the closing off of other
possible paths in their lives, but they both acknowledged that this was a necessary trade-off for being led to more meaningful paths as a result of their psychosis.
Conclusion: Implications for Further Research

It is clear that all six of these participants have been on an incredible journey to the depths of their psyches and back, having integrated what they experienced and joining the rest of us within consensus reality. They have all experienced to a greater or lesser degree the extremes of human suffering and of human joy; they all spent time mired in utter chaos and confusion and have somehow emerged with a renewed sense of equilibrium and lucidity. What is perhaps even more impressive is that they have all experienced profound healing from this journey, having emerged with greater equanimity and resilience, a richer feeling realm that includes less negativities and more unitive experiences, more rewarding and enjoyable relationships with themselves and others, and a greater overall sense of wellbeing. Regardless of the validity of any theoretical model that attempts to explain how this happened, what is ultimately more important is the evidence that such profound recovery did, and does, happen. I believe this research has been successful in adding further validity to the line of research establishing psychosis as a natural process of the psyche—a process that clearly has the potential to greatly exacerbate one’s suffering but that also has the capacity to provide healing at the most profound levels when successfully resolved.

Few would dispute the contention that one of the most important functions of society is to provide the means to minimize the suffering and maximize the joy of its members, and of course, in Western society, the mental health care system should be one of the leaders in this regard. In this study, we have examples of six different people who have all managed to rise from the depths of extreme suffering to lives that are filled with richness and meaning, but unfortunately, it seems that they have done this not so much
with the support of the mental health care system, but rather in spite of it, to a greater or lesser degree. I believe that this research offers substantial support to the other research in the field that has shown that, as a society, we have been seriously failing our most disadvantaged members in this way. Yet, I believe that this research also offers substantial hope. If these six individuals can undergo such a profoundly healing transformation in the face of such poor odds, just imagine what can be done if we take guidance from their lessons and use it to shape a health care system that offers more genuine support. But in order to do this, it is clear that more research needs to be done in this regard. An important implication of this study, however, is that we do not necessarily need to do more research; rather, we need to consider drastically changing the kind of research that we do.

The vast majority of psychosis research in Western society pays no attention to the subjective experiences of the participants, but I believe the findings of this study lend support to other research suggesting that this has been a grave mistake. As discussed in the Literature Review section, there is overwhelming evidence that members within so-called developed countries (i.e., the U.S., Europe, etc.) have much lower rates of recovery from psychotic disorders than members of the poorest countries of the world, and the results of this study suggest that the fruits of Western research in this regard has offered very little genuine support to those suffering from psychosis. In other words, it seems likely that we in the West have been barking up the wrong tree. I believe that the results of this study suggest, above all else, that the key to the genuine transformation of our mental health care system lies in listening to the subjective experiences of the consumers of that system. In other words, if we, as researchers, hope to contribute to this
transformation, then the evidence strongly suggests that we must learn to treat the mental health care consumers as partners and even as teachers. With this in mind, I hope that this study inspires many other researchers to continue the journey down this very important path.
Limitations

The most significant limitation I have found when conducting this study was my own limited time and resources. The most obvious limiting effects of this are a limited sample (both with regard to size and to demographic variety) and a less than optimal method of data collection. I had a slight preference for face-to-face interviews, since I believe that nonverbal communication can be helpful in both enriching the interview and in ensuring maximum comfort of the participants when addressing this potentially sensitive material. Due to the challenge of finding participants who met the strict criteria for this study, however, they were significantly spread out geographically, so telephone interviews were significantly more practical and affordable. I was pleasantly surprised, however, with how well all of the telephone interviews went (I was able to use videophone for only one of them). All interviews were surprisingly rich, and I found that I was able to effectively track the participants' sensitivity to the questions and to regulate our interaction accordingly so as to maximize their level of comfort.

Another limitation is that, for several of these participants, many years have passed since their psychosis, and consequently, some of their memories of the experiences have faded or been altogether lost. This resulted in receiving data that may be somewhat inaccurate and also in missing information that could have been important. Another limitation that is closely related to this is that I found it difficult at times to distinguish between the changes people have experienced as a direct result of their psychosis and the changes that may have occurred as a result of other factors or just simply their natural development over time. This was especially the case for those whom many years have passed since their psychosis. Because of these two limitations, if I were
to conduct similar research in the future, I would consider adding additional criteria in regard to this—perhaps limiting the time that has passed since their psychosis to no more than ten or fifteen years.

One final limitation worth mentioning is that I have personally suffered from psychotic experiences (as defined in this study), something that I believe was primarily a benefit in conducting this research but that also presented some minor challenges. On one hand, it was clear that having gone through these experiences myself (which I disclosed to the participants) increased my capacity to empathize with and better understand the participants’ experiences; on the other hand, I did need to take care to monitor my own biases and any tendencies to project my understanding of my own experiences onto those of the participants, which is something that I remained very mindful of throughout the entire process.
Delimitations

Even though I took significant measures in an attempt to maximize external validity, due to the limited sample, it is clear that external validity is significantly limited. The fact that there were only six participants is in itself a serious limitation to external validity. There are further limitations with regard to age, ethnicity, culture, sex, and social class. All participants in this study went through the majority of their psychotic experiences between the ages of 19 and 30. There is some chance that the age of onset may play a significant role in the experiences of long-term psychosis, so we would not be able to safely generalize the results of this study to those having these experiences at different times in their life. The participant sample was also significantly limited with regard to ethnicity and culture. All six of the participants are Caucasian and living in Western industrialized society (five from the U.S. and one from New Zealand). This significantly limits external validity to other Caucasians living with Western industrialized societies and perhaps to only those living in either the U.S. or New Zealand. Regarding gender, four participants were male and two were female, so external validity is skewed somewhat in favor of males. Regarding social class, all participants fall within the range of lower class to middle class, so external validity is limited especially with regard to upper class.
References


Appendix A:
Initial Questionnaire

Please read the following definitions closely and then answer the questions that follow. If you have any questions, do not hesitate to contact the principal researcher, Paris Williams, at [email] or [phone].

Definitions:

**Anomalous experiences**: Experiences that the mainstream mental health field would consider “hallucinations” or “delusions.” (These are distinguished from psychotic experiences in that they may or may not cause limitation and a sense of distress. For example, there are some people who hear voices that others do not hear but who do not experience any distress or sense of limitation from these experiences).

**Psychotic experiences**: Anomalous experiences that directly result in limitation and a sense of distress.

**Psychosis (or psychotic episode)**: An enduring condition in which psychotic experiences are predominant.

**Long-term psychosis**: A psychotic episode that lasts for one month or longer; or a series of psychotic episodes, the total duration of which is longer than one month.

**Recovered**: An individual who has previously experienced psychosis may be considered recovered when they have achieved relative stability in a condition in which the overall sense of suffering and limitation is the same or less than the level of that which preceded their psychosis.

There are several important points regarding this use of the term "recovered":

- We all have subjective experiences at times that are limiting and distressing (nervousness, sadness, etc.), whether or not we define them “psychotic.” Therefore, when someone is considered recovered, the implication is not that they are free from all distressing experiences, but simply that their overall level of distress and limitation is no greater than it was prior to the onset of their psychosis.

- There is evidence that we are all susceptible to having psychotic experiences, given enough stress. Therefore, we cannot say that someone considered recovered will never have psychotic experiences again, just as we cannot say that anyone will never have psychotic experiences.

- Someone may be considered recovered while still experiencing anomalous experiences. Research has shown that there are many people who have anomalous experiences that do not cause limitation and suffering. Therefore, those who continue
to experience anomalous experiences may be considered recovered if these experiences no longer create significant limits and suffering.

- Everyone experiences fluctuations in their perceived sense of wellbeing. What is important in this definition of recovered is that one’s overall sense of limitation and suffering (after accounting for the daily and weekly fluctuations) is no greater than that which preceded the psychotic experiences.

- For the purpose of this study, potential participants must demonstrate that they have been free of psychotic experiences and continuously and self-sufficiently meeting their needs without the use of psychiatric medications or the significant use of other drugs, including the excessive use of alcohol, for a minimum of three years.

**Questions:** (Feel free to attach additional pages if you need more space)

Name (Please print your full name on this form; however, in the interest of confidentiality, you will be assigned a fictitious name that will be used for the remainder of the study):

Current Age:

Gender:

Ethnicity:

Do you believe you can participate in this study without significant distress?

Based on the definition above, do you consider yourself recovered from long-term psychosis (if unsure, please describe your uncertainty)?

Do you have a therapist, a close friend, or a close relative who has known you for at least 3 years and who would be willing to sign a testimonial in this regard?

What psychiatric diagnosis(es) have you been given, if any?

If you do consider yourself recovered, how long do you estimate you have been recovered?
How well do you believe you recall the details of your psychotic experiences?

If asked to compare your life now with your life preceding the onset of your psychotic experiences, how accurately do you believe you would be able to do so?

Overall, and only generally speaking, how would you compare your sense of wellbeing and ability to meet your needs in your life now as compared to before the onset of your first psychotic experiences?

Would you say that you have spent a significant amount of time contemplating and/or processing your psychotic experiences as you moved towards recovery? If so, please describe how you have done so:

Have you recorded, in any way, aspects of your process related to your psychotic experiences? These could include any expressive arts media such as visual arts, journaling, poetry, or any other forms of writing. These could be related to experiences you had during the onset, recovery, or any stage in between. If so, please describe:

How old were you when you first began to have psychotic experiences?

Was there any clear incident that triggered your first psychotic episode (i.e., traumatic event, reaction to drug or medication, etc.)?

How many significant psychotic episodes would you estimate you had?
For approximately how long did each episode last?

What other biologically-oriented psychiatric treatment have you received (including hospitalization(s), ECT, etc.), if any:

Please describe any psychotherapy in which you participated related to these experiences (duration, modality):

Please describe your most significant psychotic experiences:

What (if any) psychiatric drugs have you taken for these experiences (please include amount, duration, and time periods):

Are you currently taking any psychiatric drugs (Yes/No)?

If “No,” how long has it been since you were no longer taking any psychiatric drugs on a regular basis?
Appendix B: Recovery Testimonial

This testimonial is to be signed by a therapist, a close relative, or a close friend of the participant who has had frequent interactions with the participant for at least three years.

I, (print full name) ____________________________, give my testimonial that, to the best of my knowledge, (print name of the participant) _________________________, has been continuously and self-sufficiently meeting his/her needs without the use of psychiatric medications or the significant use of other psychoactive substances, including the excessive use of alcohol, for a minimum of three years as of today’s date.

Signature: ____________________________ Date: ________________

Your contact information (email address and/or telephone):

Your relationship with the participant:

How long have you known the participant?

Please briefly describe the frequency and nature of your interactions with the participant:
Appendix C:
Guiding Questions for the Live Interview
(To be given to the participant at least one week prior to the interview)

- Can you describe any experiences that you believe were directly associated with the onset of your psychotic experiences?
- Can you describe any experiences that you believe were directly associated with the intensification of your psychotic experiences?
- Can you describe any experiences that you believe were directly associated with your recovery?
- Can you describe any questions, insights, paradoxes or epiphanies that you believe were directly associated with the onset of your psychotic experiences?
- Can you describe any questions, insights, paradoxes or epiphanies that you believe further intensified the psychosis?
- Can you describe any questions, insights, paradoxes or epiphanies that you believe led to recovery?
- How has your understanding and experience of yourself developed and changed within the various stages of your psychotic process?
- How has your understanding and experience of the world and/or reality developed and changed within the various stages of your psychotic process?
- What do you believe were the most helpful resources to you in your recovery?
- How would you describe your overall sense of wellbeing now as compared to that just prior to your psychotic episode?
- How would you describe your overall ability to meet your needs now as compared to that prior to your psychotic episode?
- How would you describe your relationships with others now as compared to those prior to your psychotic episode?
Appendix D:
Posttraumatic Growth Inventory
Richard G. Tedeschi and Lawrence G. Calhoun
(*the wording in question #16 has been modified slightly from the original in an effort to facilitate clarity)

Indicate for each of the statements below the degree to which this change occurred in your life as a result of your crisis. Using the following scale, circle the number to the right of each statement that best represents your answer (if filling this out on a computer, please either **boldface** or highlight the appropriate number):

1 = I did not experience this change as a result of my crisis.
2 = I experienced this change to a very small degree as a result of my crisis.
3 = I experienced this change to a small degree as a result of my crisis.
4 = I experienced this change to a moderate degree as a result of my crisis.
5 = I experienced this change to a great degree as a result of my crisis.
6 = I experienced this change to a very great degree as a result of my crisis.

1. My priorities about what is important in life.
2. I’m more likely to try to change things which need changing.
3. An appreciation for the value of my own life.
5. A better understanding of spiritual matters.
6. Knowing that I can count on people in times of trouble.
7. A sense of closeness with others.
8. Knowing I can handle difficulties.
9. A willingness to express my emotions.
10. Being able to accept the way things work out.
11. Appreciating each day.
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<td>12. Having compassion for others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>13. I’m able to do better things with my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>14. New opportunities are available which wouldn’t have been otherwise.</td>
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<td>2</td>
<td>3</td>
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<td>5</td>
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<td>15. Putting effort into my relationships.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>16. I have a stronger spiritual faith.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>17. I discovered that I’m stronger than I thought I was.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>18. I learned a great deal about how wonderful people are.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<td>19. I developed new interests.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>20. I accept needing others.</td>
<td>1</td>
<td>2</td>
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<td>21. I established a new path for my life.</td>
<td>1</td>
<td>2</td>
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Appendix E:
Recruitment Flyer

We Are Seeking Participants for a Study on Recovery from Long-Term Psychosis

We are looking for participants who may satisfy the criteria of having recovered from long-term psychosis. The study's web page defines these terms more specifically (see website address below).

This will be truly pioneering research which validates the possibility of full recovery, allowing those who have recovered from distressing anomalous experiences to contribute their wisdom and knowledge for the benefit of those who are still struggling with such experiences, as well as for the benefit of all of society.

If you are interested in learning more about this study, or if you think you may be an eligible participant, or if you know someone who may be, you can find more details at the following website:

www.recoveryresearch.moonfruit.com

Or you may contact the principal researcher directly at:

Paris Williams
[Address]

[Email]