A Review of Transpersonal Theory and Its Application to the Practice of Psychotherapy

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Transpersonal theory proposes that there are developmental stages beyond the adult ego, which involve experiences of connectedness with phenomena considered outside the boundaries of the ego. In healthy individuals, these developmental stages can engender the highest human qualities, including altruism, creativity, and intuitive wisdom. For persons lacking healthy ego development, however, such experiences can lead to psychosis. Superficially, transpersonal states look similar to psychosis. However, transpersonal theory can assist clinicians in discriminating between these two conditions, thereby optimizing treatment. The authors discuss various therapeutic methods, including transpersonal psychopharmacology and the therapeutic use of altered states of consciousness.

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The term *transpersonal psychiatry* is one with which many clinicians may be unfamiliar, but the notion of "transpersonal" as a psychological idea was, in fact, first introduced by William James more than 90 years ago.[1] The field is concerned not only with the diagnosis and treatment of psychopathology associated with the usual stages of human development from infancy through adulthood, but also with difficulties associated with developmental stages beyond that of the adult ego. It is this latter idea, that there are stages of human growth beyond the ego (hence the term *transpersonal*) that sets these theories apart from other models of human development and psychopathology. The field stands, however, not in contradistinction to these models, but rather as an extension of them. As Scotton[2] has noted,

> This newly enlarged psychiatry stands in relationship to the current psychiatry much as modern physics does to classical Newtonian physics: The current "classical" psychiatry is a subset of a larger system, the new transpersonal psychiatry. (p. 6)

Although many clinicians may be unclear about the term *transpersonal*, most have had more exposure to the field than they may realize. Some transpersonal frameworks have gained relatively broad recognition, such as

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the work of Jung or Maslow. Other approaches are less well known, such as Grof's holotropic breathwork,[3] guided imagery, or psycholytic psychotherapy.

All transpersonal approaches are concerned with accessing and integrating developmental stages beyond the adult ego and with fostering higher human development. Because of this concern, most transpersonal theories deal extensively with matters relating to human values and spiritual experience. This focus sometimes leads people to confuse the interests of transpersonal psychiatry with the concerns of religion. Transpersonal psychiatry does not promote any particular belief system, but rather acknowledges that spiritual experiences and transcendent states characterized by altruism, creativity, and profound feelings of connectedness are universal human experiences widely reported across cultures, and therefore worthy of rigorous, scientific study. Inattention to these experiences and the roles they play in both psychopathology and healing constitutes a common limitation in conventional psychotherapeutic practice and research.[4–7]

Transpersonal studies have their roots in humanistic psychology and the human potential movement of the 1960s. Since its formal inception in 1968, transpersonal psychiatry has grown steadily, and the proliferation of related research and publications attests to the growing maturation of the discipline.[8] Increased professional acceptance of the role that spirituality and religion play in the psychotherapeutic process is suggested by the inclusion in 1994 of a category for "religious or spiritual problem" in the DSM-IV.[9]

In this article, we briefly review major transpersonal theories and how these may enhance the practice of psychotherapy. In particular, we discuss how transpersonal theory can extend current models of psychosis and suggest new avenues for both differential diagnosis and treatment. Finally, we review current trends in transpersonal clinical practice and the development of new therapeutic technologies. Comprehensive review of this material is beyond the scope of this paper but can be found in several excellent texts.[10–12]

TRANSPERSONAL THEORIES AND HUMAN SPIRITUALITY

Mainstream psychotherapeutic systems have largely ignored human spiritual and religious experience, except as sources for psychosocial support. In contrast, one of the hallmarks of transpersonal approaches is the directness with which spiritual experience is addressed as part of the therapeutic process. Ultimately the goal is not merely to remove psychopathology, but to foster higher human development. The notion of higher human development is defined somewhat differently in different transpersonal systems, but most characterize it as involving a deepening and integration of one's sense of connectedness, whether it be with self, community, nature, or the entire cosmos. This process of deepening the experience of connection usually engenders the highest human qualities, such as creativity, compassion, selflessness, and wisdom, but for the unprepared individual, experiences of deep connectedness can fragment necessary ego boundaries and produce chaos, terror, and confusion. Perhaps because of this possibility, the psychotherapeutic community commonly views oceanic, mystical, or spiritual experiences with suspicion. Much of this bias may have roots in Freud's contributions to psychological thought, such as *Moses and Monotheism*[13] and *The Future of an Illusion*,[14] in which he largely characterizes spiritual experience as a regressive defense.

This thinking stands in contrast to the earlier work of William James, arguably the father of transpersonal psychology, who pioneered the psychological study of spiritual experiences in *The Varieties of Religious Experience*.[15] James's view was more pragmatic than the later Freud's, and he suggested that spiritual experiences should be judged by their effect on people, rather than prejudged based on a particular theoretical, cultural, or religious orientation.

Carl Jung was perhaps the first clinician who attempted to legitimize a spiritual approach to the practice of depth psychology.[16] Several of his contributions are relevant to the current discussion. In contrast to Freud, Jung introduced the principle of trust in one's psychological process, with the implication that consciousness has within itself inherent tendencies toward growth and evolution. This assumption has profound implications for clinical practice, since it determines whether the clinician regards what arises in the patient as revealing or obscuring the therapeutic course. In addition, Jung suggested that psychological development extends to include higher states of consciousness and can continue throughout life, rather than stop with the attainment of adult ego maturation and rational competence. He also proposed that transcendent experience lies within and is accessible to everyone, and that the healing and growth stimulated by such experience often make use of the languages of symbolic imagery and nonverbal experience,

which are not reducible to purely rational terms. In addition, Jung was among the first to examine spiritual experience cross-culturally, and his study of Eastern mysticism, African shamanism, and Native American religion has helped define the universality of human spiritual experience and its relevance to psychological health.

Abraham Maslow continued this theme with his naturalistic study of persons he considered to be "self-actualized."[17] He found remarkably consistent descriptions of the characteristics of enlightened people across cultures, and he concluded that human beings have an instinctive, biologically based drive toward spiritual self-actualization, which he characterized as a state of deep altruism, periodic mystical peak experiences producing a sense of union, and freedom from conditioned thought and behavior.[18]

On the basis of this study, Maslow developed his now-famous theory of personality and development.[19] In it, he proposed a hierarchy of needs and motivations, beginning with the most basic physiological drives for food, water, and oxygen and culminating in the emergence of a drive toward self-actualization and self-transcendence and the dissolution of preoccupation with the concerns of the ego. In later life, Maslow refined his hierarchy of needs into a three-phase model of development: a deficiency-motivated stage, a humanistically motivated stage, and a transcendentally motivated stage.[20] As Battista points out,[21] this model anticipates and closely parallels the prepersonal/personal/transpersonal model proposed some years later by Ken Wilber, a major contemporary transpersonal theorist.

Wilber's principal contributions to transpersonal developmental theory were first presented in *Transformations of Consciousness*.[22] In this work, he elaborates on a developmental model that incorporates not only the usual stages of human development suggested by Freud, Jung, Piaget, and others, but also transpersonal or transrational stages derived from non-Western wisdom traditions. Like the earlier psychological theories from which Wilber borrowed, his model is hierarchical in that he claims that reality and psyche are organized into distinct levels, in which "higher" levels are superior to "lower" levels in a logical and developmental sense. This "ladder"[23] structure of Wilber's "spectrum of consciousness" model undoubtedly relates to his use of Eastern developmental theories, in particular the chakra system of tantra yoga, which has a similar structure.[24] Each successive level subsumes the properties of the preceding level, resolves the developmental problems associated with that stage, and demonstrates new emergent qualities, as well as new developmental challenges. Thus he suggests that each stage of development is associated not only with the emergence of specific psychological structures and abilities, but, when aberrated, with specific kinds of pathology.

Wilber identifies about ten stages of human development, the first five of which roughly correspond with Piaget's stages of cognitive development up through "formal operations." He then posits a "vision-logic" stage characterized by the integration of mind and body (or thought and feeling) and associated with new emergent capacities for the direct intuition of complex patterns. Subsequent to this are four transpersonal stages: the "psychic," in which individual consciousness extends beyond the boundaries of the empirical ego, thus producing feelings of empathic understanding; the "subtle," in which consciousness gains access to archetypal forms; the "causal," in which observing consciousness merges with what is observed, engendering formless, "non-dual" awareness; and a final stage, in which one has a willingness and ability to travel among all the stages because one is free of attachment to even the "highest" states.

As mentioned previously, Wilber broadly groups these stages (with their associated emergent capacities and pathologies) into three levels: the prepersonal, personal, and transpersonal, echoing the three-stage model proposed earlier by Maslow. *Prepersonal* functioning occurs in the absence of full rational competence and an intact ego, as in the case of children or some psychotic individuals. It is largely instinctual in nature and shaped by basic biological needs. *Personal* functioning is mediated by and oriented to the concerns of the ego. Through identification with thoughts and feelings that arise out of one's attachments ("I need this," "I don't want that"), a sense of separate identity is created, and this becomes the nexus around which behavior is organized. *Transpersonal* functioning emerges when identification with personal concern diminishes, and it is associated with states of being and modes of knowing arising from connection with levels of reality beyond personal identity.

Because ego boundaries are diminished or absent in transpersonal states, subject/object relationships are altered, or in some cases completely collapse, creating the possibility of profound experiences of connectedness. Most transpersonal theorists would argue that these experiences are not mere feelings of union, but rather that in these states individual consciousness is actually con-

nected to and participating in phenomena beyond one's usual ego boundaries. Such a model may permit greater understanding of anomalistic data such as psychic phenomena and the nonlocal effects of intention—as suggested, for example, in studies looking at the effects of covert prayer on the hospital course of cardiac patients.[25] At present, the validity of such phenomena is highly controversial because current scientific paradigms cannot easily accommodate the notion that human consciousness can have distant effects.

Wilber uses his model of prepersonal, personal, and transpersonal stages to explain the apparent similarities between regressive psychotic states and experiences of mystical, transcendent union. Many poets, philosophers, and clinicians have pointed out the apparent similarities between the utterings of madmen and those of sages.[26] In both psychosis and "enlightenment," individuals appear to have altered ego boundaries and to think and act in irrational ways. But in the case of a psychotic regression, this is a prerational, pre-egoic state, and in the case of healthy mystical experience, it is a transrational state built upon and extended beyond a normal, healthy ego. Wilber names this confusion between the two conditions the "pre/trans fallacy,"[27] and Freud's criticisms of religion as a regressive defense may be partly understood in terms of this error.

The concept of the pre/trans fallacy underscores the necessity of healthy ego development as a prerequisite for constructive transpersonal experience: without it one is unable to integrate such experiences and is at risk of psychological fracture and regression into lower functioning states. Interestingly, character development is emphasized in many of the non-Western wisdom traditions that use various techniques to induce transpersonal states. Often the aspirant must go through extensive personal development and moral training prior to practicing the methods, as a safeguard to prevent subsequent spiritual difficulties.[28] Also of interest are studies showing a positive correlation between mystical experiences and enhanced psychological functioning, further underscoring the substantial difference, in spite of superficial appearances, between psychotic regression and transpersonal states.[29]

Not all transpersonal theorists endorse linear or hierarchical models. For example, in *The Unfolding Self: Varieties of Transformative Experience*, Metzner[30] rejects linear developmental models entirely and instead presents a pluralistic model of human transformation by examining common, universal metaphors for change. And in contrast to Wilber's linear paradigm, Washburn[31] presents a developmental model that can be regarded as a spiral. This paradigm, largely derived from psychoanalytic and Jungian theory, views human development as initially emerging from the preconscious depths of the psyche, differentiating into ego development in the first half of life and ultimately returning to, and ideally reintegrating with, the primordial depths in the second half of life. If ego development has been healthy and successful, this reintegration can occur at a higher, trans-egoic level; if it has not, the individual is at risk of regression and loss of function.

Although the implications of whether human development is cyclic or linear, sequential or concurrent, chaotic or ordered are very significant, most transpersonal theories have much in common despite differences on this question. Generally they emphasize a more or less three-phase process in which there are apparent similarities between the stages occurring before and after ego development. Most theories emphasize that these similarities between stages are merely apparent and that profound and significant differences exist between pre-egoic regressive states and emergent transpersonal states. In fact, the elucidation of these differences—together with the development of theoretical and clinical criteria that facilitate discriminating between pre-egoic psychotic symptoms and trans-egoic mystical experience—remains one of transpersonal psychiatry's central contributions to psychological theory and clinical practice.

The hallmark of mystical experience is a stepping out of one's self, of joining with something beyond or outside one's normal ego boundaries. It is possible, as Huxley[32] has suggested, that these experiences of union underlie humankind's spiritual and religious inspiration. These ego-transcendent states, which may involve access to transrational modes of knowing and connectedness, can be either powerfully helpful or destructive for a given individual, depending on his or her psychological preparation, cognitive functioning, and social context. Transpersonal theory provides a framework for assessing such factors so that clinicians can discriminate between cases that warrant encouragement of further exploration of spiritual experience and those that are best served by attenuation of premature contact with transrational states. In some cases, such work can help transform what might ordinarily be regarded as psychopathology into new emergent skills and abilities. The importance of such discrimination is perhaps greatest in the treatment of individuals with psychotic symptoms.

TRANSPERSONAL PERSPECTIVES ON PSYCHOSIS

> Look, my thumb touches my forefinger. Both touch and are touched. When my attention is on the thumb, the thumb is the feeler and the forefinger—the [felt]. Shift the focus of attention and the relationship is reversed. I find that somehow, by shifting the focus of attention, I become the very thing I look at and experience the kind of consciousness it has; I become the inner witness of the thing. I call this capacity of entering other focal points of consciousness—love; you may give it any name you like. Love says: "I am everything." Wisdom says: "I am nothing." Between the two my life flows. Since at any point of time and space I can be both the subject and object of experience, I express it by saying that I am both, and neither, and beyond both.[33] (pp. 268–269)

The passage above is from a transcription of dialogue with Nisargadatta Maharaj, a poor cigarette vendor in India, who in his later life came to be regarded as enlightened. It reflects one of the common features of mystical experience discussed earlier, the loss of ordinary ego boundaries. If this passage were less organized, it could easily be dismissed as the utterings of a schizophrenic. According to transpersonal theorists such as Washburn and Nelson,[23,26] one of the reasons for this similarity, and for the prevalence of religious and mystical ideation in psychosis, is the existence of a common phenomenon underlying both mystical and psychotic states. This notion of connectedness or union is present in some form in most cultures and all of the major religions. It has been given many names, including Brahman in Hinduism, the Buddha-mind, the Tao, and the Kingdom of God. This Spiritual Ground can be regarded as the source of one's sense of union with self, other people, the environment, and the universe. In yoga philosophy, this Spiritual Ground is regarded as the true nature of reality and self, with all mental activity serving only to obscure this truth by creating a sense of separate existence.[34] This concept implies that the Spiritual Ground becomes more accessible as the cognitive activity that maintains one's ego-identity diminishes. Whether one experiences contact with the Ground as edifying or destructive relates to the developmental health of one's ego at the time this contact occurs, as well as the means by which one's ego boundaries are transcended. Contact with the Ground is conceptualized as occurring through "porosity" of the ego; this can occur either through spiritual development, which allows larger and larger fields of the Ground to be identified as Self, or through illness, trauma, drugs, or impaired development, which can permit premature contact with the Ground through defective maintenance of needed ego cohesion.[26] This model, then, can account for the superficial similarity between psychotic and mystical states, and also for the significant differences between the sequelae of mystical experiences and psychosis.

Discrimination between these two conditions is essential to optimize therapy and to prevent unnecessary or even harmful treatment. Grof and Grof,[35] Lukoff,[36] and Agosin[37] have all proposed criteria for discriminating between prerational psychotic regression and authentic transrational experience. Lukoff, for example, proposes four criteria for differentiating between psychotic illness and a spiritual experience with psychotic features. He suggests that emergent, transpersonal experiences are more likely in patients with 1) good premorbid functioning, 2) an acute onset of symptoms within a period of 3 months, 3) the presence of a stressful precipitant that can account for the acute symptoms, and 4) a positive exploratory attitude toward the experience.

In addition to assisting in the discrimination between psychotic illness and "spiritual emergencies" (the term coined by Grof and Grof for emergent trans-egoic experiences),[35] transpersonal models also permit discrimination between various subtypes of psychosis. As mentioned earlier, many clinicians believe that each developmental stage engenders either new emergent abilities or psychopathology, depending on the ability of the individual to integrate the experiences associated with that stage. For example, a healthy individual who experiences what Wilber calls the "psychic" level, which mediates a sense of direct connection with someone or something outside the boundaries of the ego, may have feelings of universal love and empathic understanding, whereas someone unprepared for such a loss of boundary may respond to this stage by developing paranoid delusions in order to shore up needed ego boundaries. In both cases, the experiential substrate is one of transrational connection and loss of separateness: in the former case, this leads to constructive feelings of love, empathy, and compassion, and in the latter case, to paranoid ideation, the function of which is to generate greater separation.

Similarly, other transpersonal levels may lead to divergent experiences, depending on the preparedness of the individual. For example, a stage that brings intuitive wisdom, in which knowing is not preceded by rational

thought, carries with it the risk of individuals who reach this stage developing ego inflation and grandiose delusions, should they incorrectly ascribe this knowing to their ego. Claims of divinity, omniscience, and grandiosity may relate to problems at this developmental level. Yet when this level is attained by someone with a healthy, intact ego, the individual is likely to be judged by others as particularly wise, insightful, and intuitive.

TRANSPERSONAL THEORY AND CLINICAL PRACTICE

Such examples give some indication of how transpersonal theory may enhance diagnostic thinking regarding psychosis: it can provide ways of differentiating between regressive (pre-egoic) psychosis and transpersonal phenomena, and it can assist in the understanding of differences between various kinds of psychotic states. This added diagnostic discrimination can then be used to adapt treatment to the specific condition.

There are wide differences of opinion within the transpersonal community as to the appropriateness of doing transpersonal work with psychotic individuals. Jung,[38] Wilber,[39] and Grof and Grof[35] have argued that transpersonally oriented therapies are not appropriate for psychotic individuals, whereas Lukoff and others suggest that transpersonal psychotherapy may be particularly appropriate for psychotic disorders, even serious ones.[40] In general, initial evaluation should include not only the usual elements of a psychiatric history, but also an assessment of the patient's spiritual experiences, developmental level, premorbid functioning, and interest in exploring the symptoms. This information can assist in determining whether the psychotic symptoms are best accounted for by pre-egoic or trans-egoic mechanisms. If the psychosis is regressive, treatment is oriented toward strengthening ego function with standard pharmacotherapy and psychotherapy; in the case of a spiritual emergency with psychotic features, appropriate treatment may be more expectant, with medications used primarily to modulate, rather than suppress, loss of boundary. Education, reassurance, psychotherapy focusing on biographical issues that may arise, and mental training such as meditation can help the patient move through and eventually integrate the psychotic state.

Such an approach offers clinicians a wider range of therapeutic options than simply viewing reports of unusual or extraordinary experiences as pathological. In his book *Crossings*, Heckler[41] presents a compelling case for the constructive role that such extraordinary experiences can play in psychological and spiritual growth when individuals find the means to accept, explore, and learn from them. And given the potentially serious side effects of neuroleptic medications, enhanced diagnostic discrimination may prevent the unnecessary and potentially harmful treatment of many patients. The message of transpersonal psychiatry is that not all that looks like psychosis is illness. In some cases, these experiences represent developmental difficulties in individuals undergoing profound and important changes. In such cases, treatment should focus on safely supporting and guiding this process, rather than suppressing it. The metaphor of midwifery is relevant: imagine the damage done if "treatment" prevented delivery.

THE USE OF ALTERED STATES OF CONSCIOUSNESS IN TRANSPERSONAL THERAPIES

Most transpersonal clinicians use conventional methods of psychotherapy, perhaps along with pharmacotherapy, to assist individuals, based on the expanded views of human development we have discussed. In addition, some use methods unique to the field, and most of these involved the therapeutic use of altered states of consciousness (ASCs).

The use of ASCs is perhaps the oldest healing technique,[42,43] yet contemporary psychotherapy operates largely within the realm of ordinary consciousness. Some techniques, such as the analyst's use of the couch or hypnosis, undoubtedly induce ASCs, and it is likely that ASCs play a larger part in the therapeutic process than is generally recognized.[44]

Metzner defines an ASC as a change in thinking, feeling, and perception, in relation to one's ordinary, baseline consciousness, that has a beginning, duration, and ending.[45] In the shamanic traditions, ASCs facilitate a "journey" in which one leaves one's usual world, travels to some other realm, has experiences, perceptions, and insights, and returns, ideally changed in some constructive manner.[46] The conversion experience in Christianity is another example of an ASC in which individuals may have a profound change in thinking, feeling, and perception that is markedly discontinuous from their usual state of consciousness.

Such experiences point to an important distinction between state and trait changes. For example, a conversion experience represents a temporary change in state,

and while it is often very powerful for the individual, in itself it does not necessarily translate into changes in trait, as William James pointed out in *The Varieties of Religious Experience*.[15] Much of the disinterest of contemporary psychotherapy in using ASCs may relate to the belief that changes in state have little role in the real work of psychotherapy, that of facilitating changes in long-standing traits.[47]

Many practitioners of transpersonal psychiatry would suggest otherwise, and the use of ASCs is relatively common in transpersonal therapies. These therapists argue that helping individuals leave their ordinary states of consciousness, with the attendant maladaptive patterns, can be a powerful tool promoting new patterns of thought, feeling, and behavior. In addition, some ASCs, by virtue of qualities inherent in the experience itself, can catalyze enormously significant change. Reports of individuals who have experienced states of ecstatic union almost always include comments about the profound and lasting personal changes wrought by such experiences.[48,49] Research correlating mystical experience with improved psychological functioning does indeed suggest that people may undergo trait changes as a result of state changes;[50] moreover, the work of Jenike[51] with obsessive-compulsive patients suggests that vigorous treatment of state phenomena (obsessions and compulsions) can produce trait changes in persons with comorbid dependent, avoidant, or mixed personality disorders. Much of the hypnosis literature also supports this contention that state changes may be useful in the larger task of psychotherapy—that of producing enduring change.[52] A single peak experience, however, is unlikely to produce the kind of lasting change sought after in psychotherapy, and the best approach may involve the skillful combination of conventional psychotherapeutic techniques and the use of ASCs.

How are ASCs produced and made use of therapeutically? Many triggers have been described that can produce an ASC, including fasting, dancing, music, prayer, relaxation, sex, ritual, and drugs, and these methods are widely used by traditional cultures for healing and social bonding.[53] We will limit our present discussion to a brief review of a few methods being used or studied by transpersonal clinicians: guided imagery, hypnosis, meditation, and alterations in breathing patterns.

The therapeutic use of guided imagery involves the use of sensory-rich experience to uncover and resolve psychological difficulties. As the name of this technique implies, the therapist plays an active role in guiding patients on a journey through their fantasies, dreams, memories, and other products of the imagination. Although visual imagery is perhaps the most common, any combination of one or more sensory modalities can be used in the therapy.[54] The essential factor correlating with therapeutic efficacy, however, seems to be the richness of the sensory experience, and thus it may be useful to recruit as many of the sensory modalities as possible during the session. Guided imagery therapy is similar to visualization and meditation techniques used for thousands of years by Buddhist and yogic practitioners and to the vision quests and shamanic journeys found in traditional cultures.[55]

According to Jung, imagery is the language of intuition, and the exploration of imagery is thought to allow deeper contact with emotional and intuitive processes than would mere thought about feelings. In guided imagery therapy, an atmosphere is created that allows imagery to emerge out of a patient's unconscious processes. This method is in contrast to visualization work, which involves the intentional generation of a prescribed image. The emergence of unconscious material in guided imagery therapy is often unexpected. Patients typically find themselves on a "journey" into strangely familiar but unanticipated realms. Interpretation is avoided until the journey is complete, since engagement of the rational mind tends to inhibit spontaneous and consciously undirected generation of sensory images. Clearly this state represents an ASC, although there is seldom a formal induction. The ASC arises from the attenuation of the usual executive activities of the intellect and from the inward-directed focus on internal imagery rather than exterior sensory data.[56]

As with all ASCs, such alterations create the possibility of individuals experiencing their circumstances from new and potentially helpful perspectives. Rather than engaging a patient's defenses, guided imagery therapy can facilitate the emergence of material underneath and around those defenses, and for this reason patients should be carefully screened. Some suggest that those with borderline personality or psychotic symptoms are not appropriate candidates because of the potential for ego defenses to be overwhelmed,[57] but these conditions are probably relative contraindications at best. Linehan's use of Zen techniques and visualization with borderline patients in Dialectical Behavior Therapy[58] suggests that even patients with fragile or unstable ego functioning can benefit from such work.

Hypnosis is similar to guided imagery therapy,

although it is more properly regarded as a state rather than an activity. Some transpersonal practitioners use hypnotic regression to do what is commonly called "past life therapy," in which patients explore connections between present-day conflicts and purported experiences from previous lives. Although the theory of reincarnation associated with this technique is controversial, the method can be regarded as a variant of guided imagery therapy, in which the recollection of past lives is dealt with metaphorically rather than literally. Patients may report compelling recollections of past lives, the details of which often relate to present symptomatology. Full recollection seems to engender psychological resolution.

The prescription of meditation is another approach to using ASCs for therapeutic benefit. Meditative techniques fall into two general categories: methods that use concentration on a specific object of meditation, either internal or external, and methods that foster undirected, receptive awareness. Most techniques of prayer, yogic meditation, and Christian contemplation fall into the former category; techniques such as Buddhist vipassana or insight meditation fall into the latter. Both methods have been shown to provide physical and psychological benefits,[59] but because of differences in the actual practices, one particular method may be more appropriate for a given patient. For example, concentration practices actively focus attention on an object of meditation, to the exclusion of other stimuli. For this reason, they may be easier for patients with goal-oriented styles. Concentration practices also may be particularly effective in treating anxiety and pain conditions, since awareness of noxious stimuli is diminished as one concentrates on the object of meditation. In contrast, receptive meditation techniques, at least in the early stages, foster increased awareness of all stimuli, including painful experience, since no attempt is made to modify the contents of consciousness. This latter method is particularly suited for intact individuals seeking to deepen self-awareness. Those with a history of trauma must be properly screened and prepared, since in the short term such practices will increase awareness of traumatic memories and can worsen symptoms.

As this description suggests, meditation is not without risks. Complications include emotional lability, agitation, depression, and euphoria, but these tend to occur early in the practice and are more common in those with preexisting psychopathology.[60] Occasionally, intense meditation practices may precipitate psychosis or a "spiritual emergency" in vulnerable individuals, and in such cases the practices should cease until symptoms improve. These relatively rare complications, however, are far outweighed by the benefits of meditation, which include decreased anxiety; enhanced creativity, empathy, and self-control; and greater capacity for psychological insight.[61,62] Perhaps the most significant benefits are suggested by reports from advanced meditators about the emergence of deep feelings of peace, joy, and compassion and transcendent states of consciousness, including trans-egoic states of profound unity.[63] Meditative practices have been widely employed for thousands of years by the non-Western wisdom traditions explicitly for this purpose.

The use of alterations in breathing patterns is another ancient method for inducing ASCs. Breathing practices from yoga, Taoism, and Buddhism date back thousands of years, and more recently certain methods have been adapted as techniques for transpersonal therapy. For example, Stanislav Grof, a noted psychiatrist and LSD researcher, found that the effects of LSD could be amplified through hyperventilation, and, along with his wife, Christina, he developed a therapeutic system using breathwork to induce ASCs without drugs.

Their theoretical framework was developed through careful observation of thousands of patients undergoing psychotherapy while experiencing the effects of psychedelic drugs. Like Jung, Grof observed that associative memory is organized into collections of memories that have similar feeling tones, so that engaging a particular affect activates a set of memories linked by the presence of this common affect.[64] He calls these structures "systems of condensed experiences," or COEX systems. He postulates that at the core of each COEX system is a particular affective tone associated with powerful repressed memories from infancy and early childhood. As the individual grows, each COEX system develops its own set of defenses and semiautonomous functioning. (The concept is similar to Jung's notion of the complex.) The memories that become connected with a particular COEX system are linked not by logical or chronological order, but through their association with a common affect.

Therapy, for Grof, involves establishing contact with and completely reliving the core memories and associated affect imbedded within each COEX system.[65] Initially this was done with the use of psychedelic medications, which he describes as "non-specific amplifiers of the contents of consciousness."[66] As political realities made further study of such psychedelic therapy difficult,

the Grofs developed Holotropic Breathing as a way of inducing similar ASCs without the use of drugs.

Grof's holotropic breathwork provides sophisticated attention to set and setting, using hyperventilation techniques, bodywork, and evocative music to induce a powerful ASC; the intention is to access repressed memories, perinatal experiences, and archetypal imprinting. Attention is given not only to the induction of the ASC, but also to processing the material that arises out of it with the use of group process and art therapy.

The method is not without risks, however, both physical and psychological. Holotropic breathing is contraindicated for certain physical conditions, including pregnancy, epilepsy, hypertension, stroke, and heart problems, and it may not be suited for those with a history of psychosis or severe personality disorders, since the rapid emergence of repressed material can easily overwhelm such persons. In addition, there is a much-debated body of data suggesting that even mild hyperventilation may trigger panic in certain subsets of patients with panic disorder. However, Barlow's use of diaphragmatic breathing in the cognitive-behavioral treatment of panic disorder suggests that some of these patients may tolerate moderate breathing exercises,[67] and other reports call into question the connection between hyperventilation and the induction of panic.[68] Nevertheless, until this matter is resolved, panic disorder should be considered a relative contraindication for holotropic breathing.

Furthermore, some clinicians express concern that Grof's method gives insufficient attention to working through and incorporating the powerful experiences that can arise in holotropic breathing workshops. The ideal for many patients may be to use holotropic breathing in the context of ongoing therapy, where traumatic and difficult material can be integrated over time. For those properly prepared, this method can provide powerful, transformative access to deep realms of the psyche.

TRANSPERSONAL PSYCHOPHARMACOLOGY

Most transpersonal drug therapy involves the use of conventional psychotropic agents in ways informed by the theoretical models we have discussed. Antipsychotic medications, antidepressants, mood stabilizers, and sedatives can be used to modulate but not suppress symptoms in patients undergoing spiritual emergencies. The goal of such modulation is to attenuate the intensity of symptoms just enough to allow affected persons to constructively explore the meaning of their experiences, thereby facilitating the development of cognitive maps linking ordinary consensual reality with transpersonal states. The intention is to help the individual move through and integrate these states, rather than merely suppress symptoms. Such individuals will probably not require chronic medication, and many may simply require psychological and social support, education, and reassurance.

Hallucinogenic drugs, or psychedelics, are another class of medicines that hold promise as adjuncts to transpersonal therapy. These materials are perhaps the most powerful tools for inducing ASCs, and they have been used by shamanic cultures for thousands of years.[69,70] In industrialized societies, the therapeutic use of these medicines began in the 1950s; after the ensuing cultural upheavals, they were banned in the late 1960s. The reasons for this ban were more political than scientific,[71] and in recent years interest in the therapeutic application of these materials has been renewed.[72]

Psychedelic medications fall into two general categories: 1) the tryptamines,[73] which are serotonin analogues and include such materials as psilocybin and dimethyltryptamine (DMT), and 2) the phenethylamines,[74] which are sympathomimetic amines and include drugs such as mescaline and the "designer drug" methylenedioxymethamphetamine (MDMA), also known as "ecstasy." The tryptamines are generally regarded as more capable of inducing transpersonal states characterized by the dissolution of ego boundaries, whereas the phenethylamines generally produce effects that preserve ego functioning. This makes most phenethylamines more predictable in clinical settings than tryptamines, and MDMA and related drugs generated significant interest in the psychotherapeutic community prior to being banned in 1984. Early reports suggested that these materials could acutely decrease defensiveness, enhance empathy, and promote access to unconscious material, thereby allowing patients to do therapeutic work that would otherwise be too difficult and inaccessible. Because these effects were typically produced with minimal or no perceptual alterations, some advocated the term *empathogen* rather than hallucinogen to describe this class of materials.

There are two prevailing models regarding the therapeutic use of psychedelics in Western culture. The "psychedelic" paradigm involves the use of high doses, typically of tryptamines, to produce an ego-dissolving mystical experience. This model was favored by early

researchers in the United States, who claimed success in treating a variety of refractory conditions, including chronic alcoholism,[75] antisocial personality, autism, and distress due to terminal illness.[76] Although the research methods of some of these early investigators have left certain claims open to serious criticism, many of their findings are impressive and warrant further study.[77] Recently, researchers have begun investigating the utility of psychedelics and related drugs in treating depression,[78] alcoholism,[79] opiate addiction,[80] and the distress of terminal illness.[81]

The other psychedelic therapeutic model is the "psycholytic" paradigm, which is most popular in Europe.[82] Derived from earlier therapeutic practices such as the use of barbiturates as adjuncts to psychodynamic therapy in "narcoanalysis" and the use of mescaline and datura seeds by the Italian psychoanalyst Baroni in 1931, this technique involves giving small, carefully titrated doses of psychedelic medication to patients during the course of psychodynamic therapy. The aim is to increase access to unconscious material without overwhelming the patient or inducing transpersonal states. This method is thought most appropriate for patients with characterological or psychosomatic problems or those with a history of severe trauma.[83]

The risks of psychedelic psychotherapy include the possibility of precipitating a psychosis, since the intent is to temporarily weaken or transcend ego boundaries, and patients with poor ego defenses or psychotic symptoms may therefore have to be excluded. Psycholytic approaches may be less likely to produce psychosis. Phenethylamines carry the usual risks associated with stimulant drugs, and histories of cardiac problems, hypertension, or stroke represent relative contraindications. In addition, controversy remains regarding the possible serotonergic neurotoxicity of MDMA.[84] Nevertheless, when used clinically, psychedelics rarely produce prolonged psychosis or major complications.[85,86] Acute reactions including panic and paranoia are common, but these are regarded as part of the uncovering process to be dealt with and worked through therapeutically. Chronic adverse reactions include "flashbacks," designated in the DSM-IV as "hallucinogen persisting perception disorder," characterized by intermittent, transient perceptual alterations similar to the effects obtained during acute intoxication. This condition is poorly characterized, and the reported incidence varies from 15% to 75% of regular psychedelic users.[87] Reactions to these flashback phenomena range from extreme fear to pleasure, and as with acute effects, a patient's response to flashbacks may be interpreted psychodynamically. Regular psychedelic use without apparent harm in some traditional cultures suggests that the physical risks may be low,[88] and cross-cultural studies suggest that such use may be associated with positive social and psychological effects.[89]

CONCLUSION

Transpersonal psychiatry offers a broadened view of what it means to be human. It describes the developmental stages available to individuals as they grow from infancy to adulthood to levels of connectedness beyond personal identity. It provides models of these transpersonal states of consciousness that can assist clinicians in using patients' spiritual experiences as part of the therapeutic process. These models can also facilitate discrimination between symptoms that reflect the emergence of new levels of awareness and those that indicate regressive psychosis and compromised ego functioning. This broadened view may permit greater diagnostic discrimination and may prevent ineffective, unnecessary, or even harmful treatment. The principal therapeutic methods of transpersonal psychiatry are well known and include most of the conventional psychotherapies, but these are applied on the basis of models that take into account developmental stages ignored by ego-oriented or purely biological paradigms. In addition, transpersonal research and practice explores the therapeutic use of altered states of consciousness to facilitate connection with levels of the psyche that are often unavailable through exclusively rational or cognitive approaches. The use of imagery, meditation, breathwork, psychedelic medications, and other techniques to produce altered states of consciousness may play a significant role in the advancement of psychotherapy, but much research remains to be done.

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