Self-Transformation Through the Experience and Resolution of Mental Health Crises

Guy Albert
Private Practice, Berkeley, CA, USA

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This study investigated the spiritually positive self-transformation resulting from the experience and resolution of a mental health crisis. To participate in this study, a person's experience needed to meet 4 criteria: The individual (a) experienced a crisis affecting self-concept and reality testing, which (b) resulted in a transformation that (c) was spiritually positive—that is, integrative and meaningful—and (d) they had no current acute mental health conditions. The study was conducted in 2 phases, the first of which used assessment instruments to evaluate participants' (N = 35) appropriateness for this study relative to the above criteria. In the second phase, participants (N = 23) were selected to participate in face-to-face semistructured interviews about the overall experience: from pre-crisis through to resolution and integration. The rich interview data generated a composite statement regarding the self-transformational process. The phenomenological research design steered away from focusing solely on the crisis, which often draws great interest in clinical and research settings. Instead, participants were encouraged to exercise semantic freedom and to talk about their whole experience from beginning to end. The common denominator of participation was the experience of a spiritually positive resolution, that is, a transformational growth. Results highlight the importance of acknowledging that such phenomena occur and that they deserve greater consideration, especially in formulating a semantic around the spiritual nature of these and all experiences.

Keywords: self-transformation, crisis, resolution, spiritual emergence, spiritual emergency

Transpersonal theory has posited that spiritual maturation can meet with a number of challenges and pitfalls. The severity of these vary from mild to extreme, with the most destructive and potentially fatal difficulties appropriately designated by the term *spiritual emergency* (Grof & Grof, 1989). The term is associated with a person's *spiritual emergence* or spiritual growth, but it segregates a distinct and markedly intense, crisis-like phenomenon as a potential aspect of the emergence. Other theorists refer to similar conceptions in speaking of *transpersonal crisis* or *transformational crisis* (Hendlin, 1985), *psychic pathology* (Wilber, 1993; Treon, 2009), *high arousal states* (Fischer, 1971), *spirit possessions* (Van Dusen, 1974), *altered states of consciousness* (Silverman, 1976), *mystical experience* (Wulff, 2000), and *visionary states* or *renewal processes* (Perry, 1999). This semantic diversity highlights the nosological complexities inherent in an exploration of such phenomena. The implication within at least some of the above literature is that mental health crises can be an antecedent to a psychospiritual growth process. Fundamental to this growth is the eventual integration of the crisis into a meaningful experience. The crisis therefore becomes a function of transformational growth, a term that is used here to indicate the positive transformation resulting from the experience and resolution of a mental health crisis.

The purpose of this study (Albert, 2005a) was to investigate transformational growth, that is, the integration of the crisis into a meaningful experience, hence the delineation of the growth process as a spiritual process. For the purposes of this study, spirituality was defined as meaning-making: How people make meaning of their lives, including and especially how they might make meaning of challenging or life-threatening experiences. Therefore, a developmental conception of spirituality and the associated trials of spiritual maturation are of primary interest in this study. *Transformational growth* and *self-transformation* are used interchangeably to underscore the transformation of the self in the process of integrating life's most euphoric and most challenging experiences.

Some research on the spiritual implications of people's severe crisis experiences (Park, 1990; Perry, 1999) attempted to broaden modern psychology's

conception of mental health crises. The resolution of these crises, which was a secondary aspect of these researchers' findings, implied that the challenging experience eventually enhanced a person's psychological, philosophical, or spiritual outlook. Certain cross-cultural, anthropological, humanistic, and transpersonal perspectives (Assagioli, 1965/1993; Eliade, 1972; Grof & Grof, 1989; House, 2001; Morrison, 2012; Park, 1990; Silverman, 1967; Washburn, 1988) have upheld the phenomenon of spiritual transformation resulting from the experience of a mental health crisis. They suggest that such an experience can positively affect psychological and spiritual development and have an ultimately beneficial outcome, instead of the negative and pathological associations generally placed on severe mental health crises (Fahlberg, Wolfer, & Fahlberg, 1992). These types of crises exhibit a variety of diagnostic features, including intense psychological and physiological processes, reduced psychosocial functioning, and altered states of consciousness. They may involve a number of diagnostic criteria associated with mental health disorders found in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, (DSM-5) of the American Psychiatric Association (2013).

Instead of isolating and scrutinizing the crises themselves, the study (Albert, 2005a) took a broader developmental approach to the crisis phenomenon as integral to a spiritual maturation process, recognizing several dimensions of the experience: the phenomenological characteristics of the resulting self-transformation, the meaning that the experiencers have made of the crisis once resolved, the identifiable triggers of such a crisis, the means by which they found resolution and the factors that contributed to it, the current meaning of their post-crisis experiences, and the changes they have experienced through the crisis and resolution.

Modern psychology's efforts toward the identification and differentiation of mental health crises may have kept it from recognizing the potential benefits of the resolution and integration of these challenging events. Diagnosticians attempt to impart a structure to certain experiences by combining symptoms into commonly occurring sets and labeling them accordingly. The present investigation acknowledged that symptoms are phenomenologically appropriate elements of one's experience but avoided diagnostics because of their shortcomings in conveying the complexity and multidimensionality of phenomenal experience and

documenting the potential self-transformation that lies within even the most challenging psychological processes (Harvey & Pauwels, 2003). This study further reinforces transpersonal psychology's view of human development as incorporating and transcending ego development (Wade, 1996; Washburn, 1988; Wilber, 2000). It dovetails with the transpersonal hypothesis that certain mental health crises may be a fundamental component of people's psychospiritual development, leading to a deepened or renewed sense of self and of reality. Treatment recommendations in several research endeavors have called for at least greater acceptance, curiosity, and support of the crisis experience (Hood, 1987; Laing, 1976; Park, 1990; Perry, 1999; Tart, 2011) instead of the allopathic approach that is geared toward effectively reducing or eliminating symptoms. Some benefits of this research include the advancement of transpersonal conceptualizations of psychological disturbances and their influence on human potential, the exploration of alternative perspectives regarding mental health crises for mental health professionals, the dissemination of information that is less concerned with the socially conditioned neurosis of madness (Laing, 1976; Modrow, 1996) and that gets closer to the source, that is, the experiencers and their experiences, and an offering of solace and hope for those whose lives are affected by similar experiences.

Method

Since this study's (Albert, 2005a) focus was the experience of self-transformation, phenomenological inquiry seemed an appropriate research method. Five different phenomenological approaches to the treatment of interview data (Moustakas, 1994; Polkinghorne, 1989) were considered. Moustakas' modification of the van Kaam method of analysis was selected for its relative simplicity. The resulting phenomenological data was gathered from participants' contributions through semi-structured interviews describing the characteristics of the crisis, resolution, and integration experiences.

Participants

The objective was to gather a sample of individuals who had experienced a spiritually positive resolution of a mental health crisis. Specifically, participants had to meet four criteria for initial selection:

1. The person had experienced a significant crisis involving but not limited to distortions in self-concept and reality testing.

2. The person experienced a transformation following the crisis experience.

3. The transformation was spiritually positive.

4. The most current mental health status of the person was devoid of any acute mental health condition that could distort the findings of this study.

Each criterion was associated with an assessment instrument that was used in determining appropriateness for participation in the study. Participants' answers on the instruments indicated whether each participant's experience met the four criteria. In the spirit of phenomenology's use of assessment (Fischer, 1989), the researcher discussed the results with participants and sought elaborations on the meaning of their answers, thus establishing further rapport.

Participant Selection

Sampling occurred through snowball effect, including distribution of the announcement by hard copy and by virtual dissemination on the Internet through email lists and personal or professional contacts. Responses came from a number of US states and other countries. All participants were eventually selected for their relative proximity to the researcher to facilitate face-to-face interviews.

Instruments

Six instruments were originally used in this study. The four assessment instruments were designed as ratio scales. The results were used to indicate tendencies toward a certain state of being and valued in understanding the life events of the person being assessed (Fischer, 1989). The validity of the instruments was therefore not considered an essential issue in this study. Assessment results were occasionally useful during the interview process to further understand participants' experiences. The instruments listed below were chosen to match each of the four criteria for participant selection listed in the Participants section above:

1. The Self-Transformational Crisis Assessment (STCA—Albert, 2005a) is an instrument created for the purposes of this study to assess for the presence of a past mental health crisis experience. Through an extensive research of the literature, no other instrument was found that could perform such assessment, hence the creation of this one.

2. The Life Changes Inventory (LCI—Ring, 1984) is the unvalidated version of Ring's more recent Life Changes Questionnaire (LCQ—Ring, 1992). With Ring's permission, the LCI was slightly altered to adapt it to the study in order to assess for the presence of a transformation in the participant's experience.

3. The Spirituality Assessment Scale (SAS—Howden, 1993) is an inventory that assesses for the presence of spiritual attributes in an individual. This instrument was also unvalidated. MacDonald (2000) created a more robust assessment of spirituality, but it unfortunately referred solely to belief in a "higher power," which is not inclusive of nontheistic spiritual beliefs. Howden's instrument was the preferred instrument, and it was slightly altered with the author's permission.

4. The Bell Object Relations and Reality Testing Inventory (BORRTI—Bell, 1995) is a validated instrument used to assure that a participant was no longer experiencing the acute symptoms of the crisis.

Aside from the above instruments, two questionnaires were used in this study. The Background Information Questionnaire helped gather general demographic information about participants and general characteristics of their experiences. It was a self-administered tool with a combination of multiple choice and short answer questionnaire.

The most important instrument, the interview questionnaire, consisted of questions inspired by readings of the literature on self-transformational experiences, following a generally expected chronology: precrisis, crisis, postcrisis, resolution, and integration. Answers to these questions in face-to-face semistructured interviews provided the rich, personal data for this phenomenological study, the bulk of the researched information.

Procedures

Participants who responded to the announcement were mailed a packet with the four assessment instruments and the Background Information Questionnaire. 35 people returned the completed packets. Out of these, 23 were selected for the interview due to their relatively close geographical proximity to the researcher. Each interview lasted an average of 2 hours and 20 minutes, with the longest being about 4.5 hours. The interviews resulted in about 1,120 double-spaced pages of transcribed data, containing rich and meaningful stories about people's

spiritually positive resolution of mental health crises. Statements from the transcripts were highlighted as horizons, that is, relevant expressions of the experience. Repetitive, overlapping, and unrelated statements were eliminated, and vague statements were included in almost exact detail. The resulting horizons, called *invariant constituents* (Moustakas, 1994), were sorted and labeled into thematic clusters. The themes identified paralleled the interview protocol's chronological inquiry into the experience, from pre-crisis through to present time and future recommendations.

From these, Individual Textural Descriptions—the thoughts, feelings, struggles, and successes—of the experience were created for each participant, as well as Individual Structural Descriptions—the dynamics and conditions underlying the experience's textures. The above two descriptions for each participant's experience were combined to create Individual Textural-Structural Descriptions of the experience. From each of the Individual Textural-Structural Descriptions, a Composite Description of the meanings and essences of the experience was written both in long form and in summary.

Results

Participant Demographics and Characteristics of their Experiences

Here is an overview of interview participant demographics (N = 23) in this study (Albert, 2005a). Most (21) were Caucasian, a majority of them (14) were female, and many of them (9 and 8 respectively) were in their forties and fifties, with the youngest being in their 20s and the oldest in their 70s. All participants had at least some college, with a majority (14) having an advanced degree. Religious or spiritual preference varied, although most gave multiple answers or identified as spiritual integrationists, that is, people who draw from various religious or spiritual doctrines. Many participants were single at the time of the study. Close to half of the participants were either employed in the social service or mental health arena or studying for a degree in this field.

The Background Questionnaire also collected some of the experiences' characteristics. As these data suggest, many participants received help and guidance from mental health professionals and spiritual or religious guides, such as ministers and shamans. Several participants emphasized the extra support or care they received from friends or relatives, and from alternative healing

methods (e.g., therapeutic bodywork, or homeopathy). Most participants noted in the questionnaire that the people they sought help from or the interventions they used were beneficial because they helped participants normalize and reframe the crisis experiences.

Interview Data: The Spiritually Positive Resolution of Mental Health Crises: Composite Statement

Below is the long-form composite statement drawn from the 23 reports of participants' spiritually positive resolution of mental health crises. Moustakas (1994) recommended that the composite statement include "the meanings and essences of the experience, representing the group as a whole" (p. 121). The statements below are therefore representative of people who have experienced a spiritually positive resolution of a mental health crisis and, as such, are written in the third person. The composite statement is followed by the summary statement in which participants' quotes are inserted to corroborate each of the points of this statement and to link them back to the original data.

Precrisis self-concept and functioning. A person's life prior to a mental health crisis that is positively resolved may be affected by several cultural, relational, and vocational factors having some bearing on the crisis. Cultural factors are influential, including religious indoctrination from cultural surroundings or marginalization because of ethnicity, sexual orientation, or gender. Strains in close relationships also figure prominently in people's precrisis environments, especially with parents, significant others, and associates. Relationships laden with strife, such as a relative's mental illness, the experience of abuse, or neglectful treatment as a minor, induce strained connections. Lack of healthy relating, like codependence or abuse, may also color a person's precrisis environment. Other stressors include material dependence sometimes involving a perpetrator, self-care lacunas, and indulgence in self-destructive behavior. Work or school can also be stressful because of disdain or lack of motivation for it.

Though people can identify at least one healthy relationship, positive self-care strategy, or good work situation before the crisis, the pre-crisis psychology is revealing of a more negative view of one's environment, commonly involving lack of support, isolation, disconnection, or entrapment and with an adjoining internal response of depression, repression, projection, dissociation, or denial. General emotional instability can also be associated with this period, though for a few, the

more positive feelings in retrospect stand in contrast with the crisis. Spiritual awareness is distinct and recognizable for a few people; a lack of spirituality is the slightly more prominent tendency.

Crisis experience. Certain genetic or environmental predisposing factors appear to have an influence ex post facto. Further, activities such as meditation or Pranayama or engaging in atypical or self-destructive behavior can loosen the ego's stronghold. Predispositions notwithstanding, stressors such as death, illness, separation, abuse, or personal conflicts create an internal, destabilizing effect where the self-structure is seemingly neglected or assaulted to the breaking point, precipitating a mental health crisis. The crisis manifests in a variety of psychosomatic, behavioral, emotional, mental, psychic, and spiritual characteristics that span the breadth of human affliction and that produce a remarkable and lasting impression on the psyche. Notable among these are a sense of exhaustion, loss of vitality or appetite, insomnia, suicidal tendencies, alcoholism, hypersensitivity, feeling as if living in hell, terror, grief, wanting to give in to death, emotional overwhelm, mental dysfunction, ecstasy, dissociation, loss of control, and loss of self or ego consciousness. Though most are negative traits, difficult to be with and to experience, they are at times mixed with more positive and inviting experiences. Many people identify with or receive a common diagnosis in exploring the features of their crises. Depression presents as the most common diagnostic concern, followed by alcoholism, posttraumatic stress, mania, spiritual emergency, and bipolar disorder. The therapeutic process itself can at times induce more conditions that are crisis-like. The crisis has a marked effect on several levels of people's being in the world. It can significantly affect work or school: Though some people are able to maintain, others need to quit. People find hardship in activities of daily living or meeting emotional needs. Relationships in general are strained through the crisis, though positive relational aspects sometimes develop out of the turmoil, including seeking high quality relationships or deepening existing connections. Some try to heal the pain through unstable relationships, while others feel that relationships just feed into the crisis.

The duration of the crisis event is sometimes challenging to ascertain because of its fluid parameters: Many people nonetheless experience a very clear beginning and end to the crisis while others believe they have been born in crisis. No matter the beginning, it usually ends in adulthood in conjunction with the development of a stronger sense of self. Coping mechanisms essentially help a person maintain while under the effect of stresses and traumas. They can either help or hinder the healing process: Some coping mechanisms are less than healthy in their presentation, such as alcoholism or cutting, while other coping strategies are more life-affirming and more socially acceptable, such as academic involvement and writing.

Healing process. People's motivation to heal is sometimes perceptively activated, that is, externally initiated by a friend, relative, or doctor, or intuitively induced, that is, internally promoted by a need for, and trust in, the possibility of change. Perceptive and intuitive factors can combine to promote healing, as can, quite obviously, the removal of a traumatizing stimulus. Healing manifests in a variety of activities, some slightly more favorable than others, though such activities are likely instrumental to the healing. Common activities include informative or inspirational reading, involvement in supportive or motivational groups, research or training in a psychologically-oriented field, processing through creative expression, motivating oneself to engage in work or school activities, and participating in self-transformational seminars and classes. Unconventional activities, including Qi Gung, Yoga, Breema, channeling, or Tarot can also be helpful, as can being involved in a spiritual tradition or relying on spiritual teachings. Relationships figure prominently in people's healing by offering practical, logistical, or emotional support, or active listening, or skillful encouragements toward healing; by having one's internal process mirrored by another; by associating with others who have experienced similar crises; by having one's experiences reframed more positively; by reenacting a past traumatic relationship without the trauma; by having a nonjudgmental presence or container for holding the person in crisis; and by having a mentor recognize one's personal strengths and potential. Psychotherapy, for many, provides a container for the processing of repressed events, for positive reframing, empathy, empowerment, acceptance, de-escalation, or self-reclamation, for the modification of harmful behavior, and for the explanation of processes and insight into the nature of the crisis. For some, psychotherapy is primary to healing. Several psychotherapeutic techniques prove helpful, from Jungian analysis to crisis line interventions to being discerning about standards of practice. It can also be helpful to try more than one therapist or to

have access to inexpensive or free counseling services. Psychopharmacology also proves helpful in the healing process of some, more as a coping strategy, while for as many others it is harmful or potentially laced with stigma. Hospital psychiatric wards also hold a balance of positive and negative experiences: positive in providing a container for the most harmful effects of the crisis and negative in promoting and maintaining psychopathology in people.

Using a combination of strategies can provide the space for healing. Many people rely on the felt presence of a force or wisdom outside of consciousness (God, the universe, the unconscious) to guide them in the healing process, while others rely also or instead on a more conscious, self-motivated source of wisdom. Self-initiated cognitive reframing and other self-care strategies, particularly if disengaged from mental health professionals, figure importantly in the positive resolution. Some people's involvement with professionals is disappointing if not actually damaging. Most prominent in such negative experiences is the lack of knowledge about, understanding of, or resources for a particular crisis experience, creating a rift between therapist and patient. Negative experiences are also sometimes internally motivated through resistance to healing, such as rationalization or spiritual escapism.

Resolution and integration. Resolution expresses itself through a variety of attributes. The great reward of the positive resolution of a crisis is that such painful crisis experiences eventually become part of an individual's positive self-concept. Also notable is people's eventual acceptance of their condition. They reported a significant reduction or riddance of the symptomatology, including a lessening of the vulnerability associated with the crisis state, a return of choice, will, self-care, participation in relationships or in work or school activities, or an embodied sense of health. A healthy disposition can also be marked by the termination of psychopharmacological treatment or by friends and relatives remarking on a person's return to familiarity.

A more positive self-concept variously transforms a person's psychology. People seek relationships that are more holistic, respectful, value-based, and honoring of boundaries. They value the enriching nature of relationships, are motivated to invest in them, or generally relate with much more ease. While a few people experience a rapprochement with family, others find freedom in disconnecting from toxic family ties.

They can also distance themselves from acquaintances that no longer share common values. Unfortunately, relationships still require considerable effort in spite of the transformation.

Work and purpose often improve following a positive resolution: People either find a clearer purpose or experience a positive change of purpose or direction, though some prefer to remain noncommittal or are still conflicted about their purpose. Work can be generally satisfying for some; others are inspired by ideas and projects for the future. People who have experienced a positive resolution are moved to help others undergoing challenging experiences. Some find a calling in it by becoming mental health professionals, drawing on empathy and understanding rather than attempting to label or fix other people. To help others, some use self-disclosure or candidly offer advice.

Through their resolution, people find new resources and explore different options for self-care and use them with joy and satisfaction. Most commonly relied upon are personal support systems, individual therapy, cognitive reframing, or clarifying one's abilities and setting friendly limits. People also become more passionate about self-care, though there is always room for improvement. Emotional qualities of the resolution include empowerment to overcome life's challenges, empathy or compassion for others, and relief that the worst is over. Intellectually, the resolution manifests in an appreciation and passion for life, acceptance of life's events, and engagement in the world. It also expresses itself as a freedom of response to different situations, a trust in inner guidance rather than outside opinions, a sense of self-confidence, a better outlook on life, and a greater acceptance of human nature. A number of other cognitive changes can occur, like owning one's projections, having freedom from overresponsibility, recognizing one's gifts and abilities, contributing to a better world, and being more present-oriented.

People develop or reaffirm their trust in an inner wisdom or a higher power and are humbled by its presence. They sometimes let go into the mysterious or ineffable parts of existence or surrender to their destiny. Conversely, they may become more spiritually oriented, seek self-realization, or celebrate their divine nature. Spirituality also finds expression in creating harmony with others and the environment.

Considering the emotional, intellectual, and spiritual growth that people experience, personal crises

are at the very least opportunities for self-transformation. Transpersonal and esoteric concepts have helped many make meaning of people's crisis and resolution, such as exploring different levels of consciousness or healing past-life issues. Healing is an ongoing process; certain aspects of life will always need attention. The healing process can be an ongoing attempt to fully make sense of the crisis; external events can slightly retrigger the crisis symptomatology; regret can even surface in the form of a wish for an easier, less crisis-laden life.

Recommendations for others. People who have resolved their own crises seek to normalize others' crisis experiences to support a positive outcome in them. They will empathize with others, offer them unconditional emotional support, advise them to trust their inner authority and to seek self-understanding, or promote self-care and personal safety. They also recommend finding solace in associating with others who have experienced the same, or they self-disclose to reveal their experience of crisis and resolution. Recommended healing activities include psychotherapy, reading, or a combination of resources, though some suggest avoiding the medical model for answers to their crises. Recommendations generally come with a caveat: Because it worked for one person does not mean it will work for all.

Mental health professionals need to hold off on categorizing, interpreting, or labeling people's crises because it hinders the recovery process. Instead, professionals need to provide the container that allows people's experience to unfold and speak for itself. Professionals also need to be more spiritually astute; spiritual aspects often affect the crisis and its healing. Professionals further need to be open to other modalities and perspectives and offer these options to their clients. They can benefit from continuously learning about themselves. Some people appreciate professionals' skills, which can be significantly health promoting. Others do not hesitate to express their anger and frustration with the mental health professions. Professionals may never truly understand other people's experiences unless they have experienced the same.

Finally, people who have had a positive resolution of a mental health crisis are often surprised at how much they can reveal about themselves and their experiences, sometimes forgetting where they started. They appreciate the open and accepting container of a phenomenological interview, and the breadth of some questions makes it engaging. They also appreciate being reminded of the healing they have experienced and wish to contribute their stories so others can benefit.

Summary Statement of the Experience. Prior to a mental health crisis with a spiritually positive resolution, a person's life may be affected by cultural influences, relational strains, self-care lacunas, and vocational stresses, any of which can affect the crisis. Negatively charged features and emotional instability are more common in the pre-crisis psychology. *"I was an infant who was not loved. . ."* (Participant #20; Albert, 2005b, p. 286). Precipitation of the crisis is sometimes caused by stressors, such as death or illness, or induced through intensive practices or self-destructive activities, any of which loosen the ego's grasp on the self-structure. *"My mother became . . . a lot more ill, so it was getting like within a month of her death." "So I went to a party . . . and I took a drug—LSD, I think it was, or peyote or mescaline. . ."* (Participant #20; Albert, 2005b, p. 279).

The crisis manifests in a variety of psychosomatic, behavioral, emotional, mental, psychic, and spiritual characteristics that span the breadth of human affliction and that produce a remarkable and lasting impression on the psyche. *"I had burst. My guts were hanging everywhere. . ."* (Participant #06; Albert, 2005b, p. 83). *"I needed some rest. It's like being forced to watch brilliant movie after brilliant movie"* (Participant #11; Albert, 2005b, p. 134). *"I went back down to do some magical work to open [the door]. I ended up using dog feces"* (Participant #18; Albert, 2005b, p. 242). Some positive traits of the crisis are identified, though most are negative traits affecting relationships, vocation, or self-care. *"It was very fluid, and mostly because of the evolution of the crisis from one kind of a crisis into another kind of a crisis"* (Participant #01; Albert, 2005b, p. 7). *"I think the depression lasted decades . . . but I could function"* (Participant #35; Albert, 2005b, p. 482). *"It was pretty much hell from 7ʰ grade until I was about 24"* (Participant #39; Albert, 2005b, p. 539). *"That's a pretty profound place to be where you're hurting so much that death seems like the only solution. And I was there"* (Participant #30; Albert, 2005b, p. 411). Coping mechanisms help people maintain, though some coping mechanisms such as alcoholism are more crisis laden while others contribute to healing. *"Hey you know, this is great. This is a fun way to live. I get to drink from morning till night and if I just keep drinking I'll never get the hangover, or if I don't go to sleep then I won't wake up hung over"* (Participant #28; Albert, 2005b, p. 352).

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The will to heal can come from either or both external or internal motivations. Healing manifests through a variety of educational, inspirational, motivational, or relational activities, such as reading, psychotherapy, creative expression, or groups. *"I also started doing some work, creative work, writing and stuff, you know, tried to do music and that sort of thing"* (Participant #06; Albert, 2005b, p. 83). Interventions can also have a containing effect, such as psychiatric wards. A number of spiritual, cognitive, affective, or physical interventions were noted as beneficial. *"Having something need me helped me get out of my own sort of horrible place of feeling sorry for myself and my life. School needed something from me. My mother needed me to be alive. Those things sort of helped until I could get that back for myself. . ."* (Participant #06; Albert, 2005b, p. 84). *"I think the biggest factor was when the boyfriend that I was with . . . finally convinced me to go and get therapy."* (Participant #13; Albert, 2005b, p. 184). *"My [psychotic] husband left; that was big. . . . That was a real blessing"* (Participant #13; Albert, 2005b, p. 184).

Notable in the healing process is people's acceptance of their condition and its integration into a positive self-concept, which leads to improved relational, vocational, and self-care strategies. *"But in the end, it comes down to, what is my relationship with these people now? How do I want to conduct [my life], not from a child, helpless stance but from an adult, assertive stance?"* (Participant #01; Albert, 2005b, p. 10). *"I'm just very resourceful, you know. If one thing doesn't work, I really just go find another one"* (Participant #20; Albert, 2005b, p. 285). People also find an improved sense of purpose and a motivation to be of service. *"At work, people comment [that] I do have a great capacity for compassionate listening and empathy. And people . . . seek me out because I can be there for them, I can be present with them in whatever they're experiencing without judgment"* (Participant #28; Albert, 2005b, p. 363). A variety of other behavioral, affective, and cognitive changes occur. *"[I feel] infinitely more empowered. . . . I came through that and survived and nobody thought I could. I feel like I could do anything now"* (Participant #05; Albert, 2005b, p. 65). Noteworthy are spiritually aligned changes such as trust in a higher power or inner wisdom, surrendering to destiny, seeking harmony with one's environment, celebrating the inner divine, or seeking self-realization. *"Existence supports me, and if existence didn't support me, I wouldn't be here"* (Participant #13; Albert, 2005b, p.

191). *"I finally said, "OK God, I will go to school. I will become a doctor. Fine! If this is what you want me to do with my life, I will do it." And it's like I stepped on that path and the conveyor belt took off and everything just started to fall into place"* (Participant #39; Albert, 2005b, p. 532). Considering the above, mental health crises can be opportunities for self-transformation, though healing is an ongoing process. *"I think the truest answer would be, perhaps I'm never done [with healing], you know, that it's a continual process. It just gets subtler, it becomes much subtler"* (Participant #24; Albert, 2005b, p. 323).

People who have experienced a positive resolution seek to help others with their challenging experiences by such efforts as normalizing the experience, empathizing with the experiencer, offering support, advising them to seek self-understanding, or self-disclosing their own experiences. *"It's the darkness of the soul and if you fight it, it will take you down. . . . Death comes towards you, and you're fearful, and you fight it, and I guess if you accept it, it switches on you and becomes . . . bliss or something"* (Participant #06; Albert, 2005b, p. 95). *"If I got the sense that the other person was closer to where I was, I'd have a lot of compassion. . ."* (Participant #11; Albert, 2005b, p. 148). They recommend activities that may have worked for them and encourage people to try a variety of activities. *"Being as healthy as you can be in your diet and your exercise. That's a beginning."* (Participant #18; Albert, 2005b, p. 254). *"Just seek a quiet refuge where you can rest and recuperate"* (Participant #19; Albert, 2005b, p. 275). The medical model of addressing crises has its limitations, and labeling may be injurious. Mental health professionals should instead provide a healing container; they should be more spiritually astute and help the client explore a variety of interventions. *"I think there's a lot of judgment in the psychological field about science versus art and about strict behavioral versus transpersonal. There's really room for everything and good purposes for everything"* (Participant #01; Albert, 2005b, p. 17).

Discussion

Linear theories of development, including earlier transpersonal theory (Washburn, 1988; Wilber, 1979), incompletely accounted for the variety of growths and regressions experienced by participants whose stories favored more liberal and forgiving—and perhaps therefore more complex—conceptualizations of self-structure and development. More recent developmental theories recognize the expansions and regressions

that occur randomly throughout life by presenting a holonomic (Wade, 1996) or holarchic (Wilber, 2000) conception of human development where different developmental stages operate at once.

The interview data also seemed to highlight nosological complexities surrounding the concept of positively resolved crises: The crisis experiences manifested in several dozen psychosomatic, behavioral, emotional, mental, psychic, and spiritual features. Rather than focus on the classification of crises with a spiritually positive resolution, which was not the primary purpose of this research, the more appropriate approach resulting from this study is to acknowledge the great variety of features associated with the crisis aspect of the experience. Several diagnostic typologies of religious and spiritual problems have already been proposed (Lukoff, Lu, & Turner, 1998). Grof and Grof (1989) summarized 10 types of spiritual emergencies that may require clinical attention, and parallels may exist between this typological mapping and the experiences investigated herein. Typological refinement might be accomplished through extensive research, though the present study points to the challenges inherently present in nosological systems' attempts to clearly identify and distinguish different types of crisis experiences. Indeed, many participants stated that their experience of crisis and resolution was not well understood by the current mental health field. Also, people's interest as potential participants continued well after the initial participant gathering and came from around the world, potentially indicating people's desire for their experiences to be better appreciated.

An important hypothesis fundamental to this project was nonetheless confirmed: Not all spiritually resolved issues may be associated with spiritually based crises as defined by some of the above theoreticians and researchers. In other words, all experiences have the potential to influence spiritual development, whether or not the crisis itself has spiritually identified underpinnings. Furthermore, physical, emotional, mental, and spiritual influences can be identified within all experiences, as the present participants were able to do. This phenomenological complexity exposes the richness and variety of people's experiences. Such rich and varied phenomena can be glossed over by reductionist tendencies in clinical settings, promoted especially by both the clinician's and the patient's desire to identify and classify mental health disturbances and to select appropriate and quick treatments. The mechanistic

mapping of all processes attempts to guarantee an easier and more comfortable navigation of consciousness' ambiguous terrain and its various physical, psychological, and spiritual dimensions. This is attempted by *splitting*— making distinctions based on immediacy of symptoms— as necessary (Claridge, 2001), rather than allowing the diversity of experiences to be continuously acknowledged and potentially integrated as they emerge. The result, as several research participants suggested, is a professional distraction from the phenomenology of the crisis and resolution and from the psyche's attempt to integrate emerging psychological challenges (Holt, Simmonds-Moore, & Moore, 2008; Wilber, 2000). Such distraction can lead to limiting or avoiding the potential for growth and change (Brown & Miller, 2005; Harvey & Pauwels, 2003), focusing interventions primarily on immediate clinical concerns.

The findings are also an important reminder that nosological systems are nonexhaustive tools whose primary purpose is the transmission of symptomatological constructs. The wide range of experiential features drawn from the data begs for the loosening of nosological reins on people's experiences and the widening of treatment perspectives. Accordingly, holding a developmental perspective toward people's experiences could be instrumental in the positive resolution by turning attention away from pathology (Fahlberg et al., 1992) and toward greater breadth, inquisitiveness, and perseverance in the treatment of mental health disturbances. Such spaciousness invites the developmental exploration of people's challenging experiences and validates the spiritual nature of all phenomenology.

The data are not restrictively in favor of transpersonal therapies, but they do suggest a spiritually validating approach to healing and advocate for the exploration of human potential across the life span, inclusive of crisis experiences. Transpersonal conceptualizations of health include spiritually positive resolutions of crises. Honoring the transpersonal is honoring what is with and beyond the personal—the interconnectedness of human life with all animate beings and inanimate objects, such as in Braud's (1998) definition of *transpersonal*, and with a collective source of wisdom, such as in Jung's (1951/1959) *collective unconscious*. In this way, we are invited to acknowledge the boundlessness of the healing potential within each individual.

Participants confirmed the important hypothesis that mental health crises can be opportunities

for spiritual transformation. Other studies involving the assessment of stress-related growth (Park, Cohen, & Murch, 1996) and posttraumatic growth (Cohen, Hettler, & Pane, 1998) partly addressed this hypothesis as it concerns general and not solely spiritual growth. General indicators of transformation were also noted in this study: improved relationships, clarity and discernment within relationships, improved sense of purpose (especially a willingness to help others), better self-care strategies, greater empathy and understanding for others' experiences, and spiritual maturation.

Integration therefore appears to be fundamental to the completion of transformation. Signs of integration could be associated with the notion of *rumination*, which in this context "refers to several varieties of recurrent . . . thinking, including making sense, problem solving, reminiscence, and anticipation" (Martin & Tesser, as cited in Calhoun, Cann, Tedeschi, & McMillan, 2000, p. 522). All levels of consciousness must find a way to be "converted into enduring *structures* of consciousness (states into traits)" (Wilber, 2000, p. 15). Through the repetitiveness of rumination, discoveries that emerge from the experience or that unfold out of ruminative practice imprint themselves into awareness to become elemental to consciousness.

Rumination of this type can be especially relevant to the field of psychotherapy, where a client is encouraged to repetitively investigate challenging aspects of the psyche. Schore's (2007) work has emphasized the need for a therapeutic field that allows "for effective reception and expression of unconscious nonverbal affective communications" (p. 7). The data within the present study encourage the cultivation of spaciousness in understanding and addressing people's crisis experiences, a spaciousness that could allow for less cognitive and more affective and nonverbal expressions in the therapeutic field.

The issue of repetitive rumination is an important reminder for the healing professions. When the psyche presents with confusing, distorted, or life-threatening material, all parties involved—including mental health professionals, physicians, and the patients themselves—are subject to urgently and immediately addressing these challenging symptoms. This urgency can potentially interfere with the innate transformational processes as they present themselves, including the supportive capacity of rumination and the ability to find spiritual meaning in even the darkest aspects of existence.

A psychology of self-transformation is one that includes transpersonal conceptions of human existence but that also values the place of modalities that encourage rumination in addressing psychological disturbances and in creating space for the expression, acceptance, and integration of all experiences as integral to one's life and meaning. It understands the uniqueness of each manifestation of human life and the multiplicity of experiences with each life. It accepts that not every transformation will result in a positive resolution; in fact, no transformation will be predictable in its outcome. Nonetheless, it maintains that within all difficult situations lies a potential adaptive process (Holt et al., 2008) out of which can emerge a self-transformation that will guide the beholder toward a greater spiritual understanding of life.

References

Albert, G. (2005a). *Exploring self-transformation through the spiritually positive resolution of mental health crises* (Doctoral dissertation). Retrieved from Proquest Dissertations and Theses. (Publication number 3166465)

Albert, G. (2005b). [Transcript of research participant answers to interview questions.] Unpubished raw data.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author. https://doi.org/10.1176/appi.books.9780890425596

Assagioli, R. (1993). *Psychosynthesis.* New York, NY: Arkana. (Original work published 1965)

Bell, M. D. (1995). *Bell object relations and reality testing inventory* [Manual]. Los Angeles, CA: Western Psychological Services.

Braud, W. (1998). Integral inquiry. In W. Braud & R. Anderson (Eds.), *Transpersonal research methods for the social sciences* (pp. 95-113). Thousand Oaks, CA: Sage.

Brown, S., & Miller, W. R. (2005). Transformational change. In W. R. Miller & H. D. Delaney (Eds.), *Judeo-Christian perspectives on psychology* (pp. 167-183). Washington, DC: American Psychological Association. https://doi.org/10.1037/10859-009

Calhoun, L. G., Cann, A., Tedeschi, R. G., & McMillan, J. (2000). A correlational test of the relationship between posttraumatic growth, religion, and cognitive processing. *Journal of Traumatic Stress, 13*(3), 521-527. https://doi.org/10.1037/10859-009

Claridge, G. (2001). Spiritual experience: Healthy psychoticism? In I. Clarke (Ed.), *Psychosis and spirituality* (pp. 90-106). London, UK: Whurr.

Cohen, L. H., Hettler, T. R., & Pane, N. (1998). Assessment of posttraumatic growth. In R. G. Tedeschi, C. L. Park, & L. G. Calhoun (Eds.), *Posttraumatic growth* (pp. 23-42). Mahwah, NJ: Lawrence Erlbaum.

Eliade, M. (1972). *Shamanism*. Princeton, NJ: Princeton University Press.

Fahlberg, L. L., Wolfer, J., & Fahlberg, L. A. (1992). Personal crisis: Growth or pathology? *American Journal of Health Promotion, 7*(1), 45-52. https://doi.org/10.4278/0890-1171-7.1.45

Fischer, C. T. (1989). Personality and assessment. In R. Valle & S. Halling (Eds.), *Existential-phenomenological perspectives in psychology* (pp. 157-178). New York, NY: Plenum. https://doi.org/10.1007/978-1-4615-6989-3_10

Fischer, R. (1971). A cartography of the ecstatic and meditative states. *Science, 174*(4012), 897-904. https://doi.org/10.1126/science.174.4012.897

Grof, S., & Grof, C. (1989). Spiritual emergency: Understanding evolutionary crisis. In S. Grof & C. Grof (Eds.), *Spiritual emergency* (pp. 1-26). New York, NY: Tarcher/Putnam.

Harvey, J. H., & Pauwels, B. G. (2003). The ironies of positive psychology. *Psychological Inquiry, 14*(2), 125-128. https://doi.org/10.1177/0022167803259645

Hendlin, S. (1985). The spiritual emergency patient: Concept and example. *Psychotherapy Patient, 1*(3), 70-88. https://doi.org/10.1300/J358v01n03_09

Holt, N., Simmonds-Moore, C., & Moore, S. (2008). Benign schizotypy: Investigating differences between clusters of schizotype on paranormal belief, creativity, intelligence and mental health. In *Proceedings of Presented Papers: The Parapsychological Association 51st Annual Convention* (pp. 82-96). Winchester, UK.

Hood, B. L. (1987). Spiritual emergencies: Understanding transpersonal crises [Doctoral dissertation]. *Dissertation Abstracts International, 47*(7-A), 2511.

House, R. (2001). Psychopathology, psychosis and the Kundalini. In I. Clarke (Ed.), *Psychosis and spirituality* (pp. 107-125). London, UK: Whurr.

Howden, J. (1993). Development and psychometric characteristics of the Spirituality Assessment Scale. [Doctoral dissertation]. *Dissertation Abstracts International, 54*(1-B), 166.

Jung, C. G. (1959). Aion. In H. Read, M. Fordham, G. Adler, & W. McGuire (Eds.), *The collected works of C. G. Jung, Volume 9, Part II* (2nd ed.; R. F. C. Hull, Trans.). Princeton, NJ: Princeton University Press. (Original work published 1951)

Laing, R. D. (1976). *The divided self.* New York, NY: Penguin.

Lukoff, D., Lu, F., & Turner, R. (1998). From spiritual emergency to spiritual problem: The transpersonal roots of the new DSM-IV category. *Journal of Humanistic Psychology, 38*(2), 21-50. https://doi.org/10.1177/00221678980382003

MacDonald, D. A. (2000). Spirituality: Description, measurement, and relation to the Five Factor Model of Personality. *Journal of Personality, 68*(1), 153-197. https://doi.org/10.1111/1467-6494.t01-1-00094

Modrow, J. (1996). *How to become a schizophrenic.* Seattle, WA: Apollyon Press.

Morrison, R. A. (2012). Trauma and transformative passage. *International Journal of Transpersonal Studies, 31*(1), 38-46. https://doi.org/10.24972/ijts.2012.31.1.38

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage. https://doi.org/10.4135/9781412995658

Park, C. L., Cohen, L. H., & Murch, R. L. (1996). Assessment and prediction of stress-related growth. *Journal of Personality, 64*(1), 71-105. https://doi.org/10.1111/j.1467-6494.1996.tb00815.x

Park, R. D. (1990). *Spiritual emergencies* (Unpublished doctoral dissertation). Institute of Transpersonal Psychology, Palo Alto, CA.

Perry, J. (1999). *Trials of the visionary mind.* Albany, NY: State University of New York Press.

Polkinghorne, D. (1989). Phenomenological research methods. In R. Valle & S. Halling (Eds.), *Existential-phenomenological perspectives in psychology* (pp. 41-60). New York, NY: Plenum. https://doi.org/10.1007/978-1-4615-6989-3_3

Ring, K. (1984). *Heading toward Omega.* New York, NY: William Morrow.

Ring, K. (1992). *The Omega project.* New York, NY: William Morrow.

Schore, A. N. (2007). Psychoanalytic research: Progress and process: Developmental affective neuroscience and clinical practice. *Psychologist-Psychoanalyst, 27,* 6-15.

Silverman, J. (1967). Shamans and acute schizophrenia. *American Anthropologist, 69*(1), 21-31. https://doi.org/10.1525/aa.1967.69.1.02a00030

Silverman, J. (1976). Altered states of consciousness: Positive and negative outcomes. *Journal of Altered States of Consciousness, 2,* 295-317.

Tart, C. T. (2011). *Validating unusual experiences.* Retrieved from http://blog.paradigm-sys.com/validating-unusual-experiences/

Treon, M. (2009). *Uncreated timeless self of radiant emptiness—Onliness consciousness and commentaries. Formulations of a post-metaphysical integral transpersonal communicology.* Goodyear, AZ: Auroral Skies Press.

Van Dusen, W. (1974). *The presence of other worlds.* New York, NY: Swedenborg Foundation.

Wade, J. (1996). *Changes of Mind.* Albany, NY: State University of New York Press.

Washburn, M. (1988). *The ego and the dynamic ground.* Albany, NY: State University of New York Press.

Wilber, K. (1979). *No boundary.* Boston, MA: Shambhala.

Wilber, K. (1993). The spectrum of pathologies. In R. Walsh & F. Vaughan (Eds.), *Paths beyond ego* (pp. 148-152). New York, NY: Tarcher/Putnam.

Wilber, K. (2000). *Integral psychology.* Boston, MA: Shambhala.

Wulff, D. M. (2000). Mystical experience. In E. Cardeña, S. J. Lynn, & S. Krippner (Eds.), *Varieties of anomalous experience* (pp. 397-440). Washington, DC: American Psychological Association. https://doi.org/10.1037/10371-012

About the Author

Guy Albert, PhD, is a Licensed Psychologist with a private practice in Jungian and Transpersonal Psychology working with adolescents, adults, and couples in Berkeley, California. He's an adjunct faculty at JFK University and a former adjunct faculty at Sofia University. Dr. Albert is a Clinical and Research Consultant, and an advanced candidate in analytic training at the C.G. Jung Institute of San Francisco. He is a member of the American Psychological Association, the California Psychological Association, and Gaylesta: the Psychotherapist Association for Gender and Sexual Diversity. As a member of Gaylesta's Advocacy Committee, Dr. Albert has worked to debunk the practice of Conversion Therapy (attempts to cure same-sex attractions or gender identity) since 2010. He was significantly involved in the passage of SB 1172 in California, the first bill in the world to outlaw Conversion Therapy for minors. He is currently co-coordinating the creation of a national joint statement against Conversion Therapy by all professional healthcare associations in the United States.

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