



Kaselionyte, J. and Gumley, A. (2019) Psychosis or spiritual emergency? A Foucauldian discourse analysis of case reports of extreme mental states in the context of meditation. *Transcultural Psychiatry*, (doi:10.1177/1363461519861842).

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Deposited on: 26 September 2018

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**Title: Psychosis or spiritual emergency? A Foucauldian discourse analysis of case reports of extreme mental states in the context of meditation**

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**Abstract** (246/250 words)

Meditation is becoming increasingly popular in the West and research on its effects is growing. While studies point to various benefits of meditation on mental and physical health, reports of extreme mental states that may arise in the context of meditation have also been published. This study employed Foucauldian Discourse Analysis to examine how the phenomenology of these states has been constructed in case reports and what practices were associated with these. Systematic literature search identified 22 articles containing case presentations of extreme mental states encountered by people practicing various forms of meditation. The analysis uncovered a discursive divide between biomedical (experiences seen as psychiatric symptoms or disorders) and alternative approaches (e.g. spiritual emergencies) both of which offered their own ways of addressing them. This divide may represent wider divides amongst disciplines within and outside the mental health field that may obscure understanding the phenomenology of these experiences. The study highlights the importance of being mindful of how extreme mental states in a meditation context are spoken about as it might affect the meaning making and help-seeking of persons who experience these. It also follows that it might be helpful not to see the two discourses as mutually exclusive and at odds with one another. A supportive environment that could help persons to find meaning of their experiences and integrate them into their lives should be created through encouraging collaboration between clinicians, therapists and spiritual teachers, where a range of approaches could be available to use.

**Keywords:** meditation; spiritual emergency; psychosis; discourse; transpersonal

Meditation is a practice that has been used within various spiritual and philosophical traditions for thousands of years (Shapiro & Walsh, 1984). While some common elements can be identified, meditation encompasses a wide range of techniques (Shapiro, 1984). Different mental faculties may be used (e.g. attention, visualisation, bodily awareness) actively or passively and focus might be directed at different objects such as thoughts, images or internal energy (Sedlmeier et al., 2012). The degree of intensity of different techniques varies and a number of taxonomies of meditation exist (Komjathy, 2015). For example, Ospina et al (2008) suggested five broad categories of meditation practice which encompass mindfulness meditation, yoga, mantra meditation, t'ai chi, and qigong, which originated from Hinduism, Buddhism and Chinese martial arts and medicine (Ospina et al., 2008; Posadzki, 2010; Suchday et al., 2014). It can also be classified according to primary cognitive mechanisms involved – attentional, constructive or deconstructive (Dahl et al, 2015).

Meditation is increasingly becoming an object of scientific enquiry (Suchday et al., 2014). Attempts have been made to evaluate its effects on the brain using neuroimaging (Chiesa, 2010; Fox et al., 2014; Hazari & Sarkar, 2014) and to examine psychological variables to gain an understanding of how meditation works (Sedlmeier et al., 2012). Potential positive effects on mental health have been suggested such as enhancing psychological well-being (Josefsson et al., 2011), reducing anxiety (Chen et al., 2012; Goyal et al., 2014), stress and negative mood (Lane et al., 2007), and helping those who experience more severe mental health difficulties (Chadwick, 2005; Cramer et al., 2013; Shonin et al., 2014a; Shonin et al., 2014b, Shannahoff-Khalsa, 2004). Mindfulness-based cognitive therapy has been recommended as an intervention for recurring depression by the National Institute for Health and Clinical Excellence (NICE, CG90, 2009).

However, it has also been argued that an overly-positive picture is being painted about meditation and its benefits. For example, it has been suggested that “the dark side of meditation” which encompasses various unexpected and adverse side effects has been ignored in the scientific literature (Farias & Wikholm, 2015, p. 216; Farias & Wikholm, 2016). VanderKooi (1997) suggested that experiences of confusion, hallucinations, frightening images, irritability and extreme fear were documented as early as the 5<sup>th</sup> Century in Buddhist Teachings. A recent mixed method study by Lindahl and colleagues (2017) identified a range of distressing effects of Buddhist meditation across cognitive, emotional

and somatic domains of experience. Detailed personal accounts of these are also available (Krishna, 1985; Kornfield, 1994; Gyatso, 1995).

In published articles, these phenomena have been variously described as psychiatric symptoms, “Non-ordinary States of Consciousness” or “extreme mental states” (VanderKooi, 1997; Walsh & Roche, 1979). The main focus in the literature on extreme mental states has been individual risk factors (Kuijpers et al., 2007). Lately attempts have been made to explore the phenomenology of these in different traditions such as Buddhist meditation practitioners (Lindahl et al, 2017; Kaselionyte & Gumley, 2018) and Kundalini yoga (Kaselionyte & Gumley, 2018).

It could be argued that in order to develop a fuller understanding of these phenomena it is important to look at different ways of constructing them which may be shaped by different cultural traditions with their own epistemology and language. One of the potential ways of exploring this is by adopting the Foucauldian Discourse Analytical (FDA) approach which is concerned with how different versions of phenomena can be constructed through language and how these constructions can be culturally and historically relative (Willig, 2001).

Previous discourse analytical research conducted in the mental health field has demonstrated the power of discourse in constructing certain versions of reality and the effects these constructions have on the parties involved (Galasinski & Opalinski, 2012; Lofgren et al., 2015; Scholz et al., 2014). In this study, FDA was employed to explore the ways “extreme mental states” in meditation context have been constructed in published case reports and examine the practices associated with these constructions. It can be argued that the discourses about the “extreme mental states” potentially have important implications to meditation practitioners, meditation teachers and clinicians who may encounter these states in their practice. Furthermore, the exploration of these discourses about extreme mental states might have importance for developing a fuller understanding of these phenomena.

## **Method**

### *Theory*

Discourse analytical approaches are rooted in social constructionist epistemology which invites us to question taken-for-granted knowledge about the world and is critical of

the claims that our knowledge is based on objective and unbiased facts (Burr, 2003). Instead, it claims that human “reality is socially constructed” (Berger & Luckmann, 1967, p. 13) and that our knowledge is historically and culturally relative (Burr, 2003). Therefore, there is not one knowledge, but different “knowledges”, and the same phenomenon can be understood and described differently (Willig, 2001). Language is seen as more than a medium simply enabling communication of thoughts or a reflection of a pre-existing reality but a powerful tool that can be used to construct different versions of it (Jorgensen & Phillips, 2002; Parker, 2015; Willig, 2001).

The two major forms of discourse analysis are Discursive Psychology and Foucauldian Discourse Analysis (FDA), also known as Deconstructionism (Willig, 2001; Burr, 2003). The former is concerned with how meanings are negotiated in everyday social interactions and ideally is used to analyse naturally occurring conversations and texts (Willig, 2001). The latter, inspired by the work of the French philosopher Michel Foucault, aims to deconstruct discourses showing how they create a particular version of reality with implications in the real world, and may use any kind of written texts or even non-textual materials (Burr, 2003). This approach was chosen as the most appropriate for this study which focused on written texts that were produced with an intention to be a discourse and to present a certain way of seeing and dealing with extreme mental states that may arise in the context of meditation.

FDA views discourse not only as language but also as practice (Burr, 2003). For Foucault discourses are “practices which form the objects of which they speak” (as cited in Burr, 2003, p. 64). In other words, certain ways to see the world and be in the world become available as a result of discursive constructions, which also offer various subject positions (Willig, 2001). Subject positions are produced within a discourse and refer to positions of one’s agency and identity relating to particular forms of knowledge and practice (Hall, 1997). Furthermore, certain constructions in a culture at a certain time may become regarded as the truth or “common sense” and FDA posits that the production of such “knowledge” is closely tied in with power (Burr, 2003). Recognising marginalised accounts and alternative ways of how knowledge can be conceptualised becomes an important task in order to diffuse that power (Ceci et al., 2002). Finally, FDA is also concerned with the interaction between discourses and existing social and institutional practices which validate and reinforce one another (Willig, 2001).

### *Literature search*

A systematic literature search was performed to identify research articles about extreme mental states in the context of meditation, containing case reports of people who had these experiences. Other types of publications (books, dissertation projects, newspaper articles, conference papers) as well as research papers about the positive effects of meditation on mental or physical health and studies concerned with monitoring neurological processes during meditation were excluded.

The following bibliographic databases were searched: PsychINFO, Psychology and Behavioural Sciences Collection, Embase (1947-31<sup>st</sup> December 2014), Anthropology Plus, CINAHL, MEDLINE, SocINDEX and PsycArticles. These were accessed via EBSCOhost platform, apart from Embase (1947-31<sup>st</sup> December 2014), which was searched using the Ovid interface. The initial search terms were: [(meditat\* OR yoga) AND (mental OR psych\*)]. Additional search terms were informed by the initial literature search, which were: [Kundalini AND psych\*] and [(Spiritual crisis OR spiritual emergenc\*) AND (mental OR psych\*)]. The search was restricted to articles written in the languages spoken by the researchers: English, Russian, Spanish, French and Lithuanian. Database search was conducted in December 2014. No restrictions were applied to the start publication date. Literature search was updated in December 2016.

Screening of the identified records was performed taking the following steps. Firstly, the title and abstract were screened for eligibility. Secondly, duplicates were removed and full-text papers were assessed in order to ascertain whether they met the inclusion criteria. Thirdly, we performed a manual reference search using the selected full-text articles and the newly identified articles were reviewed for eligibility. Finally, only papers which contained case reports were included in discourse analysis.

### *Analysis*

Analysis of the texts identified in the literature search started with several readings of the texts and initial coding, which helped the researchers to immerse themselves in the data (Georgaca & Avdi, 2012). The six-step guide for FDA developed by Willig (2001) informed the analytical approach in this study. Firstly, it was identified how discursive objects were constructed in the text and the differences between these constructions were noted. Next, it was examined what was achieved in constructing the object in these particular ways. Finally, different subject positions which these discourses offer and different relationships between discourses and practices were explored.

The following questions formed the analytical framework applied to each article: “How is the phenomenology of the extreme mental states of meditators described in the text?”; “To what extent the person’s agency is acknowledged?”; “What would define the frame of reference when describing these experiences?”; “To what extent are alternative explanations incorporated?”, and “What was the response to these experiences?”. Linguistic analytical tools described by Fairclough (2004) were also utilised to closely examine the language used in the texts by looking at the lexical and grammatical features of the discourse, such as nominalisation, modality and transitivity.

### *Reflexivity and transparency*

In social constructionist approaches, objectivity is not possible because “no human beings can step outside of their humanity and view the world from no position at all, which is what the idea of objectivity suggests” (Burr 2003, p. 152). It is recommended that researchers utilising FDA are reflexive of their own knowledge claims and assumptions and acknowledge that their own articles become discursive constructions (Willig, 2001).

It is therefore important to state that author J.K. is an MSc in Global Mental Health graduate and a researcher working in the field of social psychiatry. She is interested in spirituality, non-ordinary states of consciousness and alternative non-medical approaches to supporting people experiencing distress. Author A.G. is a Clinical Psychologist and Professor of Psychological Therapy. He has a particular interest in understanding psychosis, developing psychological approaches to understanding and alleviating distressing psychosis and promoting recovery.

It should also be noted that the use of the psychiatric term “psychosis” to describe the phenomena that meditation practitioners encountered in the context of meditation was avoided in this study. Instead, the term “extreme mental states” (VanderKooi, 1997) was chosen as it captures experiences that have a degree of intensity and may prompt a change in how the individual relates to the world as well as trigger a response from meditation teachers or mental health services. Individuals who had experience of these were referred to as “persons with extreme mental states” in the text.

Finally, supporting excerpts from the articles that were analysed were presented with the findings to ensure a degree of transparency and allow the reader “as far as possible, to “test” the claims made” (Jorgensen & Phillips, 2002, p. 173).



## Findings

### *Literature search*

The results from the different stages of systematic literature search are shown in Figure 1. We identified a total of 14 044 records through the database search. These were screened on basis of title and abstract and 13 949 were excluded either because they were not research papers (books, conference papers, etc.), or did not discuss extreme mental states in the context of meditation. Duplicates were removed and 66 full-text articles were screened for eligibility. As a result of this, we excluded 49 articles because they focused on the benefits of meditation on physical or psychological health or reported on neurological experiments performed on meditation practitioners. Studies which did not contain case reports were also excluded. At this stage a manual reference search was also performed and additional five articles which met inclusion criteria were identified. A total of 22 research papers were selected for discourse analysis (Table 1). Twenty one of these were written in English and one article was in Spanish. Numbers of cases described in the papers, different types of meditation (where specified) and the discourses identified are provided in Table 1.

<Insert Figure 1 here>

<Insert Table 1 here>

### *Discourse Analysis*

We identified two main discourses in the articles, which we termed the biomedical and the alternative discourse. The majority of articles drew on the biomedical discourse to describe the phenomenology of extreme mental states and ways of these states were responded to. The alternative discourse emerged as a counter-discourse to the biomedical one, bringing with it different constructions of these experiences and offering alternative approaches to supporting people. The main characteristics of each discourse are provided below together with supporting quotes from the articles analysed.

#### ***“He claimed that he knew everything in the world” – the biomedical discourse***

In the biomedical discourse, the diverse phenomenology of extreme mental states occurring in the context of meditation was described using psychiatric language and clinical

terminology. The experiences of meditation practitioners were often framed as delusions or hallucinations and the authors seemed to describe the cases in a concise way listing what was perceived by them as “psychiatric symptoms”:

“...the patient displayed flat affect, endorsed ideas of reference and delusional thinking, and was uncharacteristically preoccupied with religious ideation...” (Lu & Pierre, 2007, p. 1761).

“She was thought disordered with pressure of speech” (Yorston, 2001, p. 210).

“...visual hallucinations, psychomotor agitation, paranoid delusions, auditory hallucinations and intense anxiety” (Trujillo et al., 1992, p. 40).

“...labile affect, mild loosening of association and very poor insight and judgement” (Chan-Ob & Boonyanaruthee, 1999, p. 926).

“...he was suddenly agitated with hyperthymia” (Xu, 1994, p. 232).

“...psychomotor retardation, and poverty of speech” (Sadzio et al., 2014, p. 145).

“...paranoid negativistic delusional thoughts, intense anxieties, mood swings and suicidal ideation” (Kuijpers et al., 2007, p. 462).

These descriptions were marked with a high degree of certainty (e.g. “...was clearly psychotic.” (Walsh & Roche, 1979, p. 1085), which was further reinforced by the implied scientific objectivity of the psychiatric examinations and psychological or neurological tests, which “revealed” or “showed” pathology in the persons described:

“Neuropsychological testing revealed marked deficits in multiple cognitive domains” (Sadzio et al., 2014, p. 146).

“Examinations revealed delusions of persecution and of reference, and auditory hallucinations” (Sethi & Bhargava, 2003, p. 1085).

“Neurocognitive assessment revealed moderate impairment in attention, mental speed, verbal fluency, verbal learning and memory, visual learning and memory and difficulty in planning and representation of 3D in 2D” (Paradkar & Chaturvedi, 2010, p. 28).

“The Rivermead Postconcussion Symptoms Questionnaire showed extroversion while the Minnesota Multiphasic Personality Inventory showed schizophrenic character” (Shan, 2000, p. 14).

In contrast to the implied scientific objectivity, the accounts of persons with extreme mental states were presented as subjective using such verbs as “claimed” and “believed”, often to emphasise the irrationality of their beliefs:

“He believed that he was able to contact God, read people’s minds and know everything” (Chan-Ob & Boonyanaruthee, p. 926).

“He claimed that he knew something special about the world including “the sea is associated with water” (Shan, 2000, p. 13).

“...believed that she was invincible” (Hwang, 2007, p. 547).

Another feature of these case presentations was that authors tended to omit the individual or personal qualities of the participant as a broader context for the experiences under discussion. Persons with extreme mental states were positioned as “patients” or “subjects” in the descriptions of their cases. They were often referred to by their title and the first letter of their name or their sex briefly stating their age and occupation and mentioning psychiatric history without going into the detail about their life context:

“During the intervals of attacks, the patient was normal” (Xu, 1994, p. 232).

“The subject had an unremarkable psychiatric family history” (Paradkar & Chaturvedi, 2010, p. 27).

“A 24-year-old Caucasian male artist was referred because of an acute sensation of being mentally split during a Hindustan type meditation” (Kuijpers et al., 2007, p. 462).

Extreme mental states were framed as psychiatric disorders or illnesses in the biomedical discourse and its authors engaged in extensive discussions on their diagnostic formulations using the established psychiatric nosology:

“According to the clinical descriptions of ICD-10, most patients were suffering from an Acute and Transient Psychotic Disorder. In the DSM-IV they would have met the criteria for a Brief Psychotic Disorder” (Kuijpers et al., 2007, p. 462).

“We initially diagnosed a major depression. ...we reappraised the above described phenomena as psychotic symptoms ...the diagnosis was changed to schizoaffective disorder ...despite the lack of hallucinations and delusions, DSM-IV and ICD-10 diagnostic criteria are fulfilled, as our patient also exhibited formal thought disorder and negative symptoms (alogia, poverty of speech, social withdrawal)” (Sadzio et al., 2014, p. 146-147).

“Considering these symptoms the diagnosis of schizophrenia was entertained according to ICD-10” (Sharma et al., 2016, p. 247).

The accounts of persons with extreme mental states and their understanding of these experiences were not generally incorporated in the articles that utilised the biomedical discourse. However, where their view was mentioned, it was framed in a way that invalidated their interpretations, awarding more weight to the authors' views:

“...she chose to deny the findings of the MRI and neurocognitive deficits, refusing neurocognitive retraining on the pretext that it was merely a result of the rupture in the “crown chakra...” (Paradkar & Chaturvedi, 2010, p. 32).

“Medication has addressed his delusions and improved his self-care, functional activities. However, he continued to see the Kundalini awakening as the life for his future” (Valanciute & Thampy, p. 840).

The authors of the biomedical discourse focused on discussing vulnerability and pre-disposing factors (such as stress, sleep deprivation, personality structure, history of mental health difficulties, discontinuation of psychiatric medication or organic vulnerability) which, in their view, contributed to the development of “psychiatric symptoms” in the context of meditation:

“...an increased risk for meditation-related occurrence of psychotic symptoms in individuals with a history of psychiatric symptoms or certain personality structure and in cases of sleep deprivation or physical exhaustion ...meditation can act as a stressor in vulnerable subjects” (Kuijpers et al., 2007, p. 462).

“Other more established risk factors for mania in this case are the positive family history of affective disorder and the discontinuation of carbamazepine” (Yorston, 2001, p. 212).

“In the case of Ms. A, the vulnerability appeared to stem from psychological stress and an organic vulnerability as indicated by the possible cerebral atrophy and empty sella state (as revealed on MRI) and compromised neurocognitive functions” (Paradkar, & Chaturvedi, 2010, p. 29).

“...a few schizoid traits could be elicited in his premorbid personality.” (Sharma et al., 2016, p. 247)

In biomedical discourse, responses to extreme mental states experienced by meditation practitioners included involuntary hospitalisation, restraint, psychiatric medication (antipsychotics) and Electroconvulsive Therapy (ECT). The descriptions of these were

characterised by the omission of agent in sentences and positioning the persons as passive recipients of the psychiatric interventions.

“She was detained and transferred to an intensive psychiatric care unit for three days where treatment with haloperidol 6mg and lorazepam 3mg was commenced” (Yorston, 2001, p. 210-211).

“...he required physical restraint” (Walsh & Roche, 1979, p. 1085).

“After her initial evaluation she was managed pharmacologically” (Paradkar & Chaturvedi, 2010, p. 27).

“He was treated timely by ECT” (Xu, 1994, p. 232).

“He was initiated on low dose Amisulpride (200 mg) concomitantly. Along with this psychoeducation to the patients and family members was given about the nature of illness and need of medication.” (Sharma et al., 2016, p. 247)

These interventions were presented as highly effective treatments, which lead to the prompt “recovery” of the persons and returned them back to “normal”. Normality and recovery in the biomedical discourse meant being calm, rational, critical of one’s delusions and free from “psychiatric symptoms” as well as returning to occupational functioning:

“...treated with aripiprazole 15mg/daily, with robust improvement in psychosis after 1 week and full resolution by 1 month... Aripiprazole was discontinued, and the patient continued to report feeling “normal” after the 4-month follow-up” (Lu & Pierre, 2007, p. 1761).

“This treatment regimen led to a rapid and complete recovery from psychotic symptoms and a gradual normalization of mood that persisted at follow-up after six months” (Kuijpers et al., 2007, p. 462).

“He was given 150mg of oral thioridazine within 4 hours was calm and rational.” (Walsh & Roche, 1979, p. 1085-1086).

“A week later, he recovered from his illness and now works as before” (Xu, 1994, p. 233).

“...treatment with neuroleptics. Alterations of perception disappeared in a few days and he was able to be critical of his delusions” (Trujillo et al., 1992, p. 40).

“He was successfully treated with antipsychotic medication and is maintaining well.” (Sharma et al., 2016, p. 247)

However, not all people with extreme mental states took medication straightaway. They had to be “persuaded” by clinicians. Non-compliance was a common theme in the

biomedical discourse. Stopping medication was described as the path to “relapse” and re-admission to the hospital.

“Mr D has been suggested antipsychotic medications, which he took after long persuasions” (Valanciute & Thampy, 2011, p. 840).

“Hospital staff noted that she initially refused to take her medication and then switched to cheeking her pills, which she subsequently confirmed.”(Hwang, 2007, p. 548).

“The patient did not follow maintenance treatment and continued to participate in the sessions of the sect, presenting two years later with another episode with similar characteristics” (Trujillo et al., 1992, p. 40).

“The patient discontinued treatment after 3 months and again became symptomatic. Treatment was reinstated and he responded rapidly” (Sethi & Bhargava, 2003, p. 382).

The majority of the articles utilising the biomedical discourse did not incorporate other frames of reference when describing extreme mental states. Where alternative cultural explanations were mentioned, the authors did not depart far from the medical model, in that these were used as means to aid psychiatric diagnosis and adherence to biomedical treatment:

“In Qi-gong cases, all Chinese authors describe a polysymptomatic psychiatric syndrome that corresponds to the Western categorical tradition so that the adoption of a separate class of culture-bound syndromes may not be appropriate” (Kuijpers et al., 2007, p. 462).

“It highlights the importance of understanding differing and varying philosophical and spiritual practices, applying it to clinical psychiatric care and placing it within a Western cultural context, especially when patients present with acute psychiatric conditions... This will aid in making informed decisions regarding the diagnosis and management of any psychiatric disorder” (Valanciute & Thampy, 2011, p. 841).

“This cultural formulation and affirmation of a local diagnostic label familiar to the patient also facilitated treatment acceptance” (Hwang, 2007, p. 559).

“Reformulating her experience led to a reduction in stigma and made help-seeking more acceptable, made treatment adherence better and reduced the patient’s internal dissonance” (Paradkar & Chaturvedi, 2010, p. 32).

Finally, it is important to note that the majority of these articles were published in journals with the focus biomedical psychiatry research such as *Psychopathology*, *The American Journal of Psychiatry*, *Journal of the Medical Association of Thailand* or *Chinese*

*Medical Journal*. However, a number of papers that utilised biomedical discourse were also found in journals that included cultural perspectives in psychiatry such as *Cultural Medical Psychiatry*, *Mental Health*, *Religion & Culture* or the *International Journal of Culture and Mental Health*. The majority of authors of the biomedical discourse were academic or clinical psychiatrists with one author being from the field of psychology. Therefore, these journals also offer an important broader structural context for understanding use of language, given these journals bring their own writing conventions.

### ***“I have not yet discovered the boundaries of my mind” – the alternative discourse***

In the alternative discourse, phenomenology of extreme mental states in the context of meditation was described using language characterised by “active” verbs and metaphors. The descriptions of the extreme mental states focused on what happened to the persons rather than what they “presented with”. First person accounts were often included:

“Bouncing, hopping, springing off her feet, she seemed motivated by some external force, driven. The breath rapid, drawn in and out in quick machine-gun bursts, her fingers clicking, snapping in stereotypic movements over and over again... She said people from other planets were after her “ (Ossoff, 1993, p. 29).

“...going down a shaft, opening doors to different realities ...she experienced an overwhelming sense of holiness and felt she had tapped into universal mind ... crackling electricity traveled up and down her spine...” She found her mind racing as she tried to figure everything out. She thought and thought and wandered around looking for her teacher, who she believed was God.” (VanderKooi, 1997, p. 36-37). “... this huge burst of energy shot through me. It was like electricity! And then there were all these voices exploding in my head. ...There was so much energy, I thought I was dying. ...For weeks I had nightmares and visions and hallucinations.” (Waldman, 1992, p. 117-118).

“He felt he did not want to live unless he could reduce this energy, that it would drive him crazy” (Hendlin, 1985, p. 83).

“...The process took me over...” (French et al., 1975, p. 56-58).

“He felt at times that either he was not real or that his surroundings were not real” (Kennedy, 1976, p. 1326).

When describing persons with extreme mental states, the authors of alternative discourse used the words “observed” and “seemed” to highlight that these were their own observations and interpretations of what was happening:

“...appeared so withdrawn, so “lost” as to be nearly catatonic. ... I observed Rosita hopping, bounding upright, springing into walls... Rosita did not appear to be trying to harm herself, but was seemingly unable to control her own trajectory” (Ossoff, 1993, p. 30-31).

“She seemed shy and perhaps a little frightened, and I noticed that I felt somewhat anxious and sad” (Waldman, 1992, p. 116).

In the alternative discourse, the individuals were referred to by name and thus by implication given personhood (even if the real name was changed for confidentiality purposes) and their interpretations of what was happening to them were incorporated into the articles:

“She thought that she was going through an enlightening experience and did not understand people's concern. She felt hurt that they pushed her away... Ada could not talk about her pain and felt that people would lock her up if she did” (VanderKooi, 1997, p. 36-38).

“I realized this week that all my visions are metaphors” (Waldman, 1992, p. 122).

“After gaining some trust in me, he confided that some of the episodes he experienced represented to him a sort of fusion with the cosmos” (Kennedy, 1976, p. 1327).

The authors of the alternative discourse conceptualised the experiences outside of the medical model framing them as cultural, spiritual or psychological phenomena:

“This woman was not psychotic, and what we had witnessed on Friday was not a psychotic episode, but was in fact, a Kundalini Awakening” (Ossoff, 1993, p.29).

“...if properly understood and treated as difficult stages in natural developmental process, spiritual emergencies can result in emotional and psychosomatic healing, creative problem solving, personality transformation, and conscious evolution” (Hendlin, 1985, p. 79).

“A distinguishing characteristic of spiritual emergencies is that despite the distress, they can have very beneficial transformative effects on individuals who experience them” (Lukoff et al., 1998, p. 29).

“Rather than being a sign of spiritual awakening Julia's reaction can be seen more simply as a response to her experiencing radical alterations in consciousness.” (Waldman, 1992, p. 132).



Another characteristic of the alternative discourse was the way in which authors' utilised self-reflexivity. They described their thoughts and feelings when encountering the persons with extreme mental states and also acknowledged the limits of their knowledge, the uncertainty of their interpretations or the constraints of their training. This created the impression that authors seemed to be keen to listen openly and non-judgementally to the person's experiences.

“At the same time, I felt a frustration and personal disappointment, almost a kind of betrayal at my own blindness, my inability to go beyond, to “transcend” the psychiatric explanation of her experience until she uttered the magic word, “Shaktipat”, I also wondered to what degree we in the mental health field are so “hemmed in” by our training or cultural perspective, that we view events in an unvarying way. In other words, if this is a psychiatric center, then she must be psychotic!” (Ossoff, 1993, p. 36-37).

“...although I had worked with a variety of spiritually related issues, my knowledge of kundalini was limited. ...I was somewhat skeptical [sic] about the phenomenon of kundalini, but I looked forward to meeting Julia and discussing her experience in more detail” (Waldman, 1992, p. 116).

“However, my lack of understanding of her changing religious identification hindered my ability to empathize with her... to be as open as possible to the internal struggles in both myself and my client; to listen without pretence” (Waldman, 1992, p. 133-134).

However, we also noted that there were also examples of “diagnostic certainty” and apparent authority that were observed in the biomedical discourse. These were also apparent in some of the authors in the alternative discourse: “Friday became crystal clear - Rosita had undergone a Premature Kundalini Awakening (PKA)” (Ossoff, 1993, p. 33).

With regard to responding to extreme mental states, the approaches associated with the alternative discourse included support from a teacher or spiritual guide, supportive listening, “grounding” techniques, changing the diet, “normalising” the experiences and stopping meditation practice for a while:

“...advanced meditators need a qualified teacher to help with the practice ...teachers generally assure students that such phenomena occur with deepening practice but will pass. ...Teachers

may also have more frequent interviews with the student, decrease the student's sitting time, and involve the student in "grounding" physical activities" (VanderKooi, 1997, p. 40-42)  
"First, I suggested she refrain from meditation for at least three months to allow the body and mind to assimilate the experiences, as well as the psycho-physiological changes she had gone through. ... I therefore suggested a number of routines to help reduce vata, I gave her a list of foods, a diet. ... She was also instructed to exercise moderately, since exercise would "ground" her in her body..." (Ossoff, 1993, p. 38-39).

"I listen supportively to and am accepting of their significance to him without in any way labelling them "pathological". ... (Hendlin, 1985, p. 85-86).

"...Another key component of treatment of spiritual emergencies is normalization of and education about the experience ... because persons in the midst of spiritual emergencies are often afraid that the unusual nature of their experiences indicates that they are "going crazy" (Lukoff et al., 1998, p. 41-2)

The outcomes of these alternative approaches were not extensively discussed in the alternative discourse. However, in some articles, the positive outcomes for the persons and some follow-up information were included.

"One week after Rosita was brought to us, she went home with her family - tired, curious, mystified, a little confused... She thanked us for "everything" and left... Rosita stated she was meditating again and was looking for a therapist as well. No occurrences of kundalini-induced physiological arousal or mental confusion had reappeared. Rosita was not taking any medication, but did ask what herbs might be suggested for her. The overall tone of the letter was hopeful, optimistic, and showed broad awareness, the awareness of one who is in the midst of emotional change, but who has a grasp of who she is and what steps she must take to continue her evolution and development." (Ossoff, 1993, p. 40 -41)

"She told me that she was doing quite well, although she was still uncertain about what her crisis meant. Still, she found her involvement with the church quite calming and peaceful. "In fact," she announced, "I'm considering becoming a nun." (Waldman, 1992, p. 129)

The authors who conceptualised extreme mental states in the context of meditation as spiritual emergencies/transpersonal crisis also emphasised the "reliance on the client's self-healing capacities" (Lukoff et al., 1998, p. 41-42). They adopted a critical stance towards the traditional psychiatric interventions (such as antipsychotic medication) that according to them are used to control and suppress extreme mental states, which "can lead to chronicity and long-term dependence" (Hendling, 1985, p. 79-80).

In the situations where medication was administered or physical restraint was used, the agent performing the action or making decisions was not omitted, suggesting that responsibility for these actions was acknowledged:

“There were four or five of us with her, and we attempted to hold her, protect her from hitting into walls. ... The chief psychiatrist decided to give Rosita an anti-anxiety agent to calm her” (Ossoff, 1993, p. 31).

There was also willingness to incorporate other frames of reference such as Western psychological understandings of mental health difficulties and the acknowledgment of the complexity of differentiating between spiritual crises and mental health problems or organic brain disorders:

“Certainly, not all experiences of unusual states of consciousness and intense perceptual, emotional, cognitive, and psychosomatic changes are “spiritual emergencies” or can be treated by the new strategies. A good medical and psychiatric examination is necessary to rule out brain dysfunction or diseases of other organs or systems of the body” (Hendlin, 1985, p. 81).

“While supporting Robert’s framing of issues within a spiritual context, I made it clear to him that I believed basic psychological – developmental issues had been neglected which were now causing great conflict and which needed attention” (Hendlin, 1985, p. 85).

“The opposite see”nario [sic] is also likely. I’ve been in meditation courses where individuals with serious emotional disorders pass for “evolved” (Ossoff, 1993, p. 37).

“Making the differential diagnosis between a spiritual emergency and psychopathology can be difficult because the unusual experiences; behaviours; and visual, auditory, olfactory, or kinesthetic perceptions characteristic of spiritual emergencies can appear as symptoms the symptoms of mental disorders: delusions, loosening of associations, markedly illogical thinking, or grossly disorganised behaviour” (Lukoff et al., 1998, p. 39).

The articles that utilised this discourse were published in psychology or psychotherapy oriented journals such as *The Psychotherapy Patient*, *Journal of Humanistic Psychology* or *Journal of Transpersonal Psychology* which published three out of five alternative discourse articles included in this study. The authors came from the field of clinical psychology and counselling. As with the biomedical discourse, this is also an

important broader context to interpreting use of language and the construction of individuals' experiences of extreme mental states.

### ***Mixed discourses***

It should be noted that some articles (French et al., 1975; Kennedy, 1976; VanderKooi, 1997) contained both the biomedical and the alternative discourses. For example, Kennedy (1976) incorporated the understanding of the persons who had an “out-of-body” experience after meditating, noted that these people could be referred to spiritual groups for support and guarded against the use of phenothiazines in these situations. However, he referred to these people as “psychiatric casualties” and predicted that the numbers of these would be rising as “more inherently disturbed individuals are attracted to groups with incompetent leaders” (p. 1327).

Similarly, the article by French et al. (1975) included rich first person accounts of their experiences (“I was in a state of openness and readiness for new growth; I felt that there were unreached areas in my mind and that there must be more to life.” (p. 55). However, their discourse was also characterised by clinical descriptions of the phenomena (“the affect became dysphoric...”, “She displayed substantial use of intellectual processes...” (p. 56) and the reliance on psychological tests (“The Minnesota Multiphasic Personality Inventory (MMPI) profile indicates...”, “Psychological test results at this point indicate a moderate thought disorder.” (p. 56).

Finally, while the majority of Vanderkooi's (1997) article could be interpreted as utilising the alternative discourse as illustrated in the alternative discourse section, there were also parts of it that could be seen as biomedical. For example, the author described one of the interviewee's experiences as a “psychotic break” (p.35) and at times used clinical terms for her reflections: “experiences of Sara and Ada suggest that narcissistic issues around grandiosity and borderline issues around abandonment can be activated in more advanced stages of meditation” (p. 43).

## **Discussion**

### ***Main findings***

We identified two discourses that were prevalent in the literature on extreme mental states occurring in the context of meditation. The authors who utilised the biomedical

discourse constructed the extreme mental states of meditation practitioners as pathological. The phenomenology was described using clinical language and psychiatric diagnostic nosology, implying the scientific objectivity of psychiatric examinations and tests. The biomedical discourse reflected the assumption that “a scientific way of looking at the world provides an unmediated, direct knowledge of reality, “the way things actually are” (Donnelly, 1997, p. 1046).

The language used by the authors of the biomedical discourse implied a sense of authority and “expertise”. The authors engaged in discussions about the persons’ psychiatric diagnosis, which served to produce a person’s “subjective identity” as a “psychiatric subject”, which influence how the persons understand themselves and how they are perceived by others (Roberts, 2005). These psychiatric subjects were positioned as passive recipients of “highly effective” psychiatric interventions (e.g. medication and ECT) to bring them back to “normal”.

The alternative discourse emphasised looking at these phenomena through a different lens and suggested an array of non-medical ways of supporting people with extreme mental states. In contrast to some biomedical case studies that described both patient symptomology and subsequent responses to treatment, efficacy of these alternative approaches was not a focus of extensive discussion and this may reflect a lack of emphasis on treatment based research surrounding the alternative discourse.

Describing these phenomena as “spiritual emergencies” was one of the main ways to conceptualise these experiences without pathologising them. Adopted by Transpersonal Psychology, this approach acknowledges that extreme mental states can often be difficult and frightening but also recognises the potential for spiritual growth and healing (Grof & Grof, 1989). From this perspective, psychiatric medication used to suppress these experiences is seen as potentially harmful for one’s spiritual growth (Grof & Grof, 1989; Johnson & Friedman, 2008; Lukoff et al., 1995).

It could be noted that both discourses could be seen as equally biased and to a certain degree obscuring the phenomenology of extreme mental states. The biomedical discourse while focusing on alleviating distress and functional impairment from extreme mental states emphasised the claims of expertise and superiority of scientific knowledge and was more reluctant to incorporate other frames of reference. The alternative discourse, while demonstrating self-reflexivity and willingness to give agency to persons who reported these experiences, focused on criticising the biomedical approach which in turn prevented them

from seeing the bigger picture and recognising that some persons might benefit from various ways of support, including psychiatry.

This discursive divide on extreme mental states in meditation represents and is reinforced by the divide between the disciplines in the mental health field. The biomedical discourse articles were published mainly in biomedical psychiatry journals by psychiatrists and the alternative discourse was produced by psychologists. None of the articles presenting an alternative construction of extreme mental health appeared in the 'mainstream' psychiatry journals but were rather published in more 'niche' journals such as the *Journal of Transpersonal Psychology*. It could be argued that overcoming this division would lead to developing perhaps a more balanced understanding and more comprehensive support for persons who encounter extreme mental states in their meditation practice.

Finally, the writing style expected of authors and different research methodologies as well as restrictions implied on authors by the publisher could have also played the role in creating the divide between the discursive constructions of extreme mental states. The authors of alternative discourse used more qualitative approaches and included large amounts of quotes provided by people who shared their experiences of extreme mental states. The style that is also often includes reflexive commentary is more prominent in *Transpersonal Psychology* literature. In contrast, the articles that were categorised as biomedical may have been limited to more brief case reports that have particular style of reporting symptomatology and do not always allow much diversion from this.

### ***Strengths and limitations***

The aim of this study was to identify the discourses about extreme mental states in meditation context and how these discourses may impact on the approaches taken to address these. While a number of articles that used biomedical discourse discussed the risk and vulnerability factors, such as history of mental health problems or the intensity of meditation practice, these were not a focus of our study.

Foucauldian Discourse Analysis (FDA) aims to identify how different versions of phenomena are constructed through language and what are the effects of this in the real world (Willing, 2001). Adopting FDA as the overarching approach and using linguistic analytical tools (Fairclough, 2004) to look at fine details of the texts proved helpful in uncovering the divide which currently exists in the literature on extreme mental states in the context of meditation and the approaches in supporting people who experience them. This was

strengthened by the study's focus on case reports, which could be seen as "an arena in which claims to knowledge are made and epistemological assumptions are displayed" (Anspach, 1988, p. 357).

However, the findings could be seen as one of many possible readings of the articles and may have been influenced by the values, beliefs and backgrounds of the researchers. Therefore, extensive quotes from the texts analysed have been provided to demonstrate rigour of the analysis and ensure transparency.

The heterogeneity of extreme mental states described in the articles could be seen as a limitation of this study. We used the term "extreme mental states" to avoid adopting a particular discursive stance (e.g. calling the experiences psychotic). However, the variability in the phenomenology of these experiences is wide which makes it difficult to draw clear cut lines between the biomedical and alternative discourses and categorise the articles accordingly. It may be that certain phenomenology may lend itself more to one framework than the other. It is also possible that some experiences can be addressed better by one framework than another.

Furthermore, the presence of both biomedical and alternative constructions in some of the articles raises the question whether these two discourses can be seen as mutually exclusive or totally at odds with one another. Both those experiencing extreme mental states in the context of meditation and those who support them in the clinician or spiritual field may have multiple frames of reference when trying to make sense of these experiences. This can be illustrated by Kaselionyte & Gumley (2018) study, where Buddhist meditation teachers acknowledged both the possibility of spiritual difficulties in meditation that they could work with and mental health problems that needed referral to a mental health professional. An important implication of this observation is the need for cross-disciplinary approaches to extreme mental states, which incorporate multiple perspectives drawing upon a broad range of perspectives including those with lived experiences of extreme mental states.

### ***Implications and future research***

Meditation is becoming increasingly popular in the West. In the rising "media and scientific hype" (Van Gordon et al, 2015, p. 4) on its effects on mental health it is important to be mindful of the way we employ discourses to describe extreme mental states that might arise in one's meditation practice.

Research points to the importance of the interpersonal context – awareness of the other’s views as pathologising or normalising – when integrating out of ordinary experiences into one’s life, including the opinions of significant others and professionals that people seek help from (Heriot-Maitland et al., 2012; Sedláková & Řiháček, 2016). Therefore it is important not to rush into applying labels to experiences that are less understood phenomena. There are dangers in adopting solely either biomedical or alternative discourse and seeing them mutually exclusive. While some people may find spiritual emergency framework more acceptable, there is a risk that this can delay access to healthcare when this may be needed. Others might find the biomedical approaches limited or not helpful and should be able to access resources outside of this framework. Efforts could be made to create a supportive environment for people to integrate their extreme experiences and find meaning congruent with their values, beliefs and cultural backgrounds.

Collaboration between spiritual teachers, therapists and clinicians could be a good starting point as well as raising awareness about a range of options available to persons with extreme mental states. For example, the International Spiritual Emergence Network supports people through spiritual crises worldwide and brings together mental health professionals and experts by experience ([www.spiritualemergencenetwork.org](http://www.spiritualemergencenetwork.org)). Transpersonal psychotherapy is among the therapies available, which focuses on both healing of personal issues and promoting spiritual growth (Bagdon, 1990). There is the need to expand evidence base on these alternative therapies using established research methodology which could provide more confidence for clinicians in recommending these to persons experiencing extreme mental states.

Further research could explore the phenomenology of extreme mental states through the in-depth interviews with meditation practitioners, spiritual teachers and clinicians which could provide a more nuanced understanding of this phenomenon (e.g. Kaselionyte & Gumley, 2018; Lindahl et al, 2017). A wide range of systems of knowledge with their own ways of conceptualising and dealing with phenomena could be explored making space for these diverse understandings to co-exist within the empirical paradigm of evidence base (Kirmayer, 2012). Perhaps the most important thing when exploring phenomenology of such experiences is bracketing our judgements and keeping an open mind, or in Tagore (1913)’s words, starting one’s journey “with empty hands and expectant heart” (as cited in Ossoff, 1993, p. 40).



## **Conclusion**

The study identified two predominant discourses in published case reports on extreme mental states in the context of meditation, which differed in their constructions of the phenomenology of these experiences and the way peoples' meaning-making and agency were taken into account. Social constructionist epistemology in which this work was embedded provided useful lens to critically examine the knowledge claims made by the authors of these discourses and consider the implications of their rhetoric in clinical practice. The findings of this study highlight the importance of thinking critically about social, cultural and political context that literature is constructed in and questioning the evidence that is presented as 'scientific' and 'neutral'.

**Declaration of Conflicting interests:** None

**Acknowledgements:** None

**Funding:** The author(s) received no financial support for the research, authorship, and/or publication of this article.

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## Tables and figures

Figure 1 – results of systematic literature search

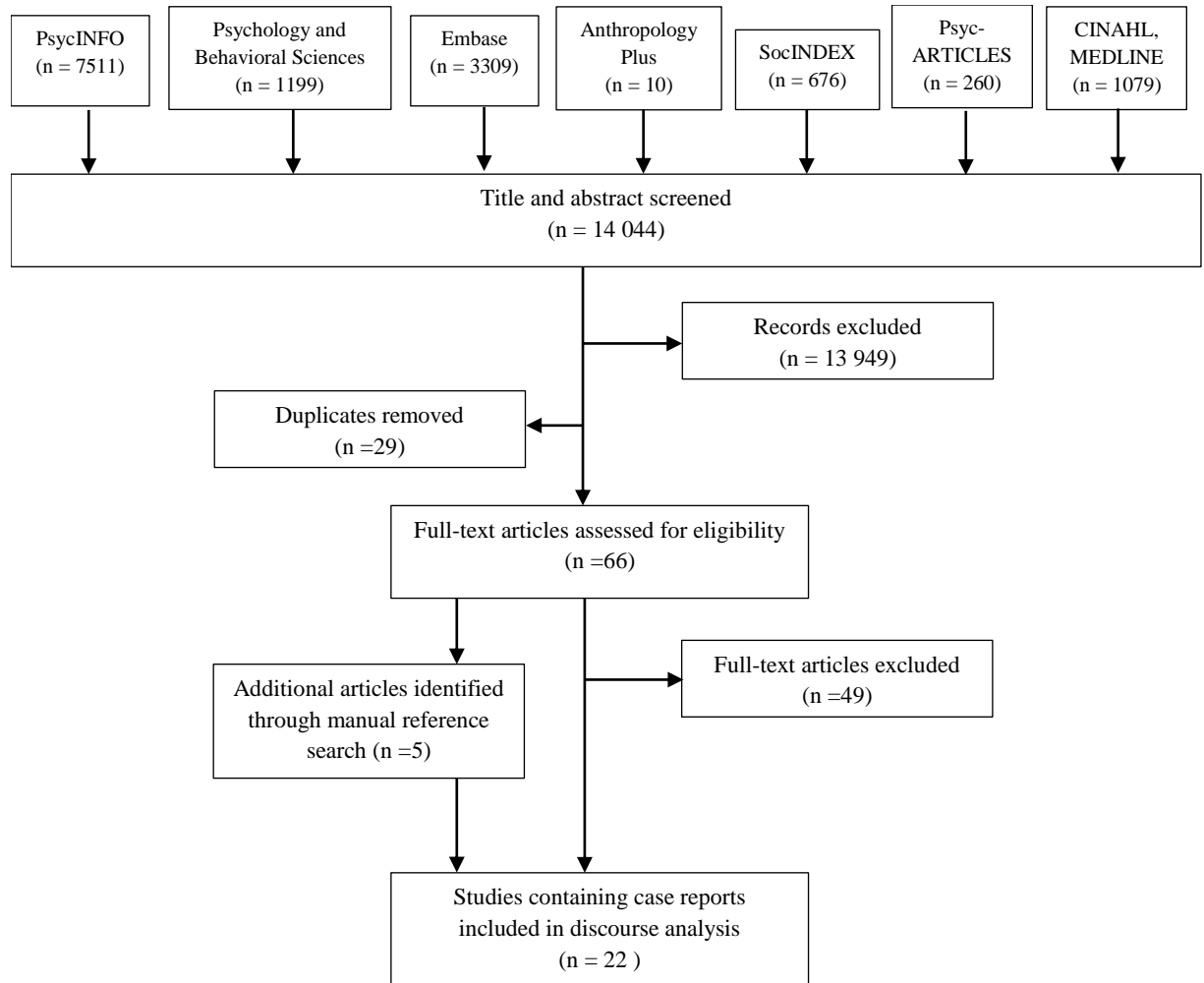


Table 1 – articles included in discourse analysis

Author(s) & Publication Year	Journal	Type of meditation	N of cases	Discourse
Chan-Ob & Boonyanaruthee (1999)	<i>Journal of the Medical Association of Thailand</i>	Unspecified type of meditation	3	Biomedical
French, Schmid, & Ingalls (1975)	<i>The Journal of Nervous and Mental Disease</i>	Transcendental meditation	1	Mixed
Trujillo, Monterrey, & González de Rivera (1992) (Spanish)	<i>Psiquis: Revista de Psiquiatría, Psicología y Psicosomática</i>	Unspecified type of meditation	2	Biomedical
Hendlin (1985)	<i>The Psychotherapy Patient</i>	Unspecified type of meditation	1	Alternative
Hwang (2007)	<i>Culture, Medicine and Psychiatry</i>	Qigong meditation	1	Biomedical



Kennedy (1976)	<i>American Journal of Psychiatry</i>	Unspecified type of yoga Arca meditation	2	Mixed
Kuijpers, van der Heijden, Tuinier, & Verhoeven (2007)	<i>Psychopathology</i>	Hindustan-type meditation	1	Biomedical
Lim & Lin (1996)	<i>Cultural Medical Psychiatry</i>	Qigong meditation	1	Biomedical
Lu & Pierre (2007)	<i>The American Journal of Psychiatry</i>	Bikram yoga	1	Biomedical
Lukoff, Lu, & Turner (1998)	<i>Journal of Humanistic Psychology</i>	Unspecified type of meditation	1	Alternative
Ossoff (1993)	<i>Journal of Transpersonal Psychology</i>	Siddha Yoga (Kundalini meditation)	1	Alternative
Paradkar, & Chaturvedi (2010)	<i>International Journal of Culture and Mental Health</i>	Kundalini meditation	1	Biomedical
Sadzio, Vieker, Gruber, & Zilles (2014)	<i>The American Journal of Psychiatry</i>	Pranic healing meditation	1	Biomedical
Sethi, & Bhargava (2003)	<i>Australian and New Zealand Journal of Psychiatry</i>	Unspecified type of meditation	2	Biomedical
Shan (2000)	<i>Hong Kong Journal of Psychiatry</i>	Qigong meditation	1	Biomedical
Sharma, Singh, Gnanavel, & Kumar (2016)	<i>Irish Journal of Psychological Medicine</i>	Transcendental meditation	1	Biomedical
Valanciute, & Thampy (2011)	<b><i>Mental Health, Religion &amp; Culture</i></b>	Kundalini yoga	1	Biomedical
Vander-Kooi (1997)	<i>Journal of Transpersonal Psychology</i>	Buddhist meditation	3	Mixed
Waldman (1992)	<i>Journal of Transpersonal Psychology</i>	Kundalini meditation	1	Alternative
Walsh & Roche (1979)	<i>The American Journal of Psychiatry</i>	Unspecified type of meditation	3	Biomedical
Xu (1994)	<i>Chinese Medical Journal</i>	Qigong meditation	2	Biomedical
Yorston (2001)	<b><i>Mental Health, Religion &amp; Culture</i></b>	Yoga and Zen Buddhist meditation	1	Biomedical