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Challenging and Adverse Meditation Experiences: Toward a Person-Centered Approach

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Abstract and Keywords

Challenging meditation experiences have been documented in Buddhist literature, in psychological research, and in a recent qualitative study by the authors. Some of the central questions in the investigation of this topic are: How are meditation-related challenges to be interpreted or appraised? Through which processes are experiences determined to be expected or “normative” aspects of contemplative development versus undesirable “adverse effects” or psychopathology? And is it possible to differentiate or disambiguate the two? A review of available research suggests that distinguishing between experiences that are religious or mystical and those that indicate psychopathology depends on detailed knowledge of the specific contexts in which these experiences occur. Furthermore, research that specifically examines meditation-related challenges shows that interpretations, causal explanations, and recommended responses are often negotiated between practitioners and other people in their practice settings and larger social communities. This chapter considers some of the social dynamics of these appraisal processes and explores some of the consequences of adopting different appraisals. However, because there can be a lack of consensus around how experiences should be interpreted or appraised, a more useful question may be: What type of support does this particular experience require? Systematic attention to social context can both inform research on meditation-related challenges and provide guidance on the issues surrounding their appraisal and management in both clinical and non-clinical contexts.

Keywords: meditation experiences, meditation-related challenges, adverse effects, person-centered approach

Introduction

Literature from many religious traditions on the theory, practice, and result of meditation tends to emphasize processes of self-transformation that culminate in changes in consciousness or modes of understanding ascribed ultimate value. The contemporary science of meditation has often reframed these practices as a means of attaining physical health or psychological well-being. Although some difficulty or discomfort might be expected in learning to meditate and undergoing a process of self-transformation, these changes are typically described in positive terms. In both religion and science, the notion that extremely challenging and adverse experiences can arise during or as a result of meditation has been downplayed or ignored. Most scientific research does not report adverse effects and generally relies on passive monitoring on the assumption that meditation is safe (Wong et al., 2018). However, a range of meditation-related challenges have been documented in both traditional religious literature and contemporary psychological research. Challenging experiences include perceptual changes such as hypersensitivity to stimuli or hallucinations, and cognitive changes such as impairments in executive functioning or delusions. Affective changes include increased emotional lability and emotional blunting, re-experiencing of traumatic memories, and a wide range of specific emotions such as fear, anxiety, and depression. Somatic or physiological changes also occur, including intense pain, involuntary movements, and disrupted sleep. Changes in motivation and sense of self can also lead to challenges, especially when there is impairment or loss of ordinary functioning. Many of these and other challenging experiences also have deleterious impacts on social and occupational functioning.

How are such experiences to be understood? When are they indications of practice gone wrong? When are they intended effects that signal the undoing of habitual patterns that will ultimately draw a practitioner closer to the intended goal? These questions are of great theoretical and practical importance for meditation practitioners and for those who seek to understand the mechanisms and implications of meditative practices. This chapter introduces the topic of meditation-related challenges and focuses on how certain experiences are appraised within Buddhist conceptions of self-transformation, in clinical psychology and psychiatry, and at the intersection of these domains. Based upon Buddhist textual sources, prior scientific and psychological research, and qualitative data from the authors' study of Buddhist meditators in the West (Lindahl et al., 2017), this chapter will describe specific meditation-related challenges, their impact on the lives of meditation practitioners, and how both appraisals of and responses to meditation-related challenges are situated in cultural contexts. The scope of this chapter is limited to studies and texts concerning Buddhist meditation and will not comment on challenging or adverse effects in the context of other meditation traditions or in contemporary programs such as mindfulness-based interventions.¹

While research on meditation-related challenges has tended to focus primarily on individual experiences, a small number of qualitative studies have begun to explore how meditation-related challenges are negotiated in broader socio-cultural contexts. The reports offered by meditation practitioners and teachers in these studies call attention to

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the processes through which teachers appraise and manage meditation-related challenges in their students. These studies have also begun to identify the scope of meditation teachers' authority and expertise, especially in situations where the meaning and nature of meditation-related experiences is contested. There is often a lack of consensus around which types of experiences should be deemed "normative" within the context of a Buddhist framework of self-transformation—that is, experiences that could occur, are expected to occur, or even ought to occur as "part of the path." Moreover, contemporary practitioners in the West regularly have to reconcile Buddhist frameworks with other, sometimes conflicting worldviews. Consequently, meditation practitioners, meditation teachers, and meditation communities, as well as psychologists and psychiatrists can all contribute to determining what constitutes a meditation-related "adverse effect" and what constitutes a "normative" meditation experience, as well as how to best respond to them when they occur.

Types of Meditation-Related Challenges

Buddhist literature provides various characterizations of how to practice meditation and the ideal trajectory of contemplative development. This is often presented in terms of a path structure (Pali *magga*; Skt. *mārga*) in which practices are developed in stages and meditation experiences are also expected to develop sequentially to some extent (Buswell & Gimello, 1992). Sharf (1995) argued that these texts rarely if ever serve as straightforward descriptions of experience, highlighting instead how paths are means of organizing Buddhist ideas in prescriptive and even polemical terms. Gyatso (1999) countered that, at least for Tibetan Buddhism, there is a rich history of describing experiences across various literary genres. Nevertheless, few textual sources provide descriptions of the range of meditative experiences or advice on how to work with specific challenging or adverse experiences.

How different types of meditation experiences are evaluated, interpreted, or appraised depends upon both the type of experience in question as well as the perspective of the teachers, clinicians, or researchers involved in the appraisal. In research contexts, the objectives of the study and the use of interview or self-report methods all impact the degree to which challenging, difficult, or adverse experiences are likely to be reported. Clinical case reports are a common source for descriptions of distressing and functionally impairing meditation experiences; however, these tend to include only those cases brought to clinical attention, and because of that setting are usually associated with psychiatric diagnoses (e.g., Chan-Ob & Boonyanaruthee, 1999; Yorston, 2001). By contrast, studies investigating mystical experiences may catalog a range of changes, but tend to emphasize positively framed experiences (e.g., Chen et al., 2011). While open-ended qualitative research may capture both positive and negative experiences (e.g., Kornfield, 1979; Shapiro, 1992), studies directly inquiring about challenges are the most reliable methods for documenting these experiences (VanderKooi, 1997; Lomas et al., 2015; Lindahl et al., 2017; Kaselionyte & Gumley, 2018).

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The most comprehensive study to date to investigate challenging meditation-related experiences is the Varieties of Contemplative Experience (VCE) project (Lindahl et al., 2017). This study employed a mixed-methods research design using outlier or deviant case sampling in order to investigate experiences associated with the practice of different forms of Buddhist meditation that were unexpected, challenging, difficult, distressing, or functionally impairing. The VCE study also investigated how such experiences are interpreted and understood by practitioners and teachers, their impact on the lives of practitioners, and the ways in which both practitioners and teachers respond to meditation-related challenges. In the subsequent sections, we adopt the classificatory scheme of the VCE study to provide an overview of some of the most commonly reported meditation-related challenges in case studies, qualitative and quantitative research, and Buddhist textual sources.

Perceptual Changes

Changes in the perceptual domain range from benign and even expected experiences such as hypersensitivity to light, sound, or body sensations, to more unusual and unexpected experiences such as distortions in space and time, derealization, and visions or visual hallucinations. Reports of visual lights are given varied appraisals across Buddhist traditions ranging from an unimportant side-effect of practice to a sign of progress in concentration that should become a new meditation object (Lindahl et al., 2014). A qualitative study of advanced Burmese meditators documented increased perceptual sensitivity and clarity, which were framed in terms of a valued insight into impermanence (Full et al., 2013). Yet, even a commonly reported change such as perceptual hypersensitivity can be appealing in one context, such as during a retreat, but considered a challenge or unwanted effect in another context, such as when a practitioner leaves the retreat and resumes ordinary life. Shapiro (1992) described how following an intensive Vipassanā retreat, some meditators experienced “societal adverse effects” including feeling “hypersensitive in the city environment” (p. 65). Perceptual hypersensitivity-related challenges following intensive practice were also found in the VCE study.

Other types of perceptual changes are more ambiguous in their significance for the meditator and are often negotiated through interactions with an authority such as a meditation teacher. For example, whether a practitioner reports a visual experience as a “vision” or as a “hallucination” depends in part on their expectations, goals, and feedback from their teachers or their tradition, which illustrates how phenomenology and appraisals are closely related. In addition to being the most commonly reported perceptual change in the VCE study (Lindahl et al., 2017), visions and hallucinations have been documented in many other previous studies of meditation experiences (Kornfield, 1979; Miller, 1993; VanderKooi, 1997; Chan-Ob & Boonyanaruthee, 1999; Chen et al., 2011; Lomas et al., 2015). For example, Chen and colleagues (2011), in a qualitative study of Chinese Buddhists using Hood’s mysticism scale, reported a range of perceptual experiences. Visual experiences of seeing light or the Buddha were valued positively by some practitioners but in other cases were rejected as hallucinations (p. 663). In Zen

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Buddhism, the term *makyō* is used to refer to largely perceptual distortions that indicate some progress in practice; however, *makyō* are also treated as being of little significance or importance lest they become pursued as an end unto themselves (Aitken, 1982; Sogen, 2001). Similar to the Zen term *makyō*, in Tibetan Buddhism *nyam* (Tib. *nyams*) refers to various types of meditation experiences, including visions, that can be signs of progress but which are generally to be regarded as incidental to the purpose of meditation.

Tibetan Buddhist practitioners and teachers in the VCE study were more inclined than those of other traditions to offer positive or mixed appraisals of visions, perhaps because of the greater importance of visionary experiences in Tibetan Buddhism (e.g., Gyatso, 1998; Doctor, 2005; Jacoby, 2015).

Teachers from Theravada Buddhist traditions tended to express skepticism or concern over reports of visions or visual hallucinations. Indeed, in some Theravada texts, visual experiences such as lights and images of the Buddha are appraised as one of the “corruptions of insight” (Pali *vipassanā-upakkilesā*) (Buddhaghosa, 1991; Sayadaw, 2016). Like *makyō* and *nyam*, these experiences may be signs of a developing practice, but they are also viewed with caution due to their allure and potential to destabilize practice. Kornfield (1979) reported a wide range of perceptual changes, including alterations in body image and visual phenomena, described alternately as visions and hallucinations. Kornfield concluded that “unusual experiences, visual or auditory aberrations, ‘hallucinations,’ unusual somatic experiences and so on, are the norm among practiced meditation students” (p. 51).

While isolated and short-lived perceptual changes might be easily negotiated as a part of the path, such experiences tend to be more concerning when they are associated with additional features such as agitation, strong negative emotions, mania, delusions, or disruptive behaviors. For example, VanderKooi (1997) described the case of a woman who re-experienced a traumatic memory that then led to a period of intense fear, insomnia, and visual hallucinations, which resolved when she discontinued practice and took medication. According to a Theravada Buddhist teacher interviewed in the VCE study, if visual experiences are not interfering, the response could be to just continue practicing. However, if they also coincided with not eating and sleeping and being “wound up in an ecstatic way,” then the practitioner would “need grounding.” Thus, the appraisal of a perceptual experience depends on the context of practice (e.g., in which tradition of Buddhism and in which setting) and also, in some cases, on the occurrence of other changes in functioning that suggest a need for additional support or intervention.

Affective Changes

Within and beyond the VCE study, a wide range of changes in affect or emotion has been associated with meditation. Affective states such as bliss and joy have been reported, and these are generally framed as positive and in relation to stages of the path (Kornfield, 1979; Chen et al., 2011; Berkovich-Ohana et al., 2013); however Buddhist literature also contains cautions concerning positive states (e.g., Sayadaw, 1965; Lingpa, 2015). Positive emotions can also develop into intensely euphoric or manic experiences that practitioners

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can find frightening or destabilizing (Yorston, 2001; Lomas et al., 2015). Studies have also documented increased emotional sensitivity or reactivity, anxiety, and depression (Kornfield, 1979; Shapiro, 1992; Miller, 1993; Lomas et al., 2015), and in other cases, blunted affect or loss of affective response altogether (Kornfield, 1979).

Experiences of fear or terror were among the more commonly reported intense affective experiences in the VCE and other studies (Kornfield, 1979; Shapiro, 1992; Kutz et al., 1985; VanderKooi, 1997; Chan-Ob & Boonyanaruthee, 1999). The VCE study documented both primary fear, in which fear arose on its own, as well as secondary fear, in which fear was a response to another change such as a hallucination or a loss of sense of self. Both types of experiences can also be found in Buddhist literary sources, which identify fear, terror, panic, and related affective states as possible consequences of meditation practice, although determinations of their cause, importance, and need for intervention vary. In Tibetan traditions, experiences of intense fear are acknowledged as a potential consequence of insight into the selflessness of persons or phenomena, even in some cases arising simply from hearing discourses on the teachings of emptiness (Pabongka, 1991). In his nineteenth-century treatise *The Vajra Essence*, Dudjom Lingpa enumerated a number of *nyam* associated with the practice of *śamatha* meditation. Emotional experiences are the most frequently mentioned, ranging from an “ecstatic, blissful sense [of] mental stillness” to “unbearable misery.” Also mentioned among his list of *nyam* are “an inexplicable sense of paranoia” and “fear and terror” concerning a variety of topics “because your mind is filled with a constant stream of anxieties,” such that you experience “everything around you leading to all kinds of hopes and fears” (Lingpa, 2015, pp. 23–24). As with *makyō*, these experiences are framed as being transient signs of progress, and practitioners are warned not to become overly concerned about or attached to them. However, modern teachers have also acknowledged that *nyam* may “become so disturbing that psychological counseling or medical intervention may be necessary” (Wallace, 2006, p. 107).

In Theravada Buddhist traditions, certain experiences of fear and terror are also viewed as normative. Buddhaghosa’s fifth-century *The Path of Purification* includes as part of the path various “insight knowledges” (*vipassanā-ñāna*), two of which are described as “knowledge of appearance as terror” and “knowledge of danger” (Buddhaghosa, 1991). According to modern commentators and teachers of the Southeast Asian Vipassanā tradition, meditators progress through the various insight knowledges in sequence, and these two insights are framed as particularly challenging and difficult stages. In contrast to Buddhaghosa and other earlier sources, for whom these stages are a way of characterizing insights into the impermanence and unreliability of phenomena, the tradition of Mahasi Sayadaw has tended to place more emphasis on their affective character (Sayadaw, 1965; Namto, 1989; Sayadaw, 2016). Some modern Western interpreters in this tradition have dubbed this trajectory of difficult stages as the “dark night,” borrowing the term from the Carmelite mystic St. John of the Cross (Kornfield, 1993; Ingram, 2008). While some research studies on challenging meditation experiences have presented fear and terror as expected parts of the path (Kornfield, 1979) or as experiences from which the practitioner can learn (Shapiro, 1992), others have

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considered fear a potential warning sign of more serious adverse effects (VanderKooi, 1997).

Another significant and commonly reported affective challenge is the re-experiencing of traumatic memories (Kutz et al., 1985; VanderKooi, 1997; Miller, 1993; Lomas et al., 2015; Lindahl, 2017; Kaselionyte & Gumley, 2018). Miller (1993) reports a case of a woman engaged in a three-month mindfulness meditation retreat who began experiencing pain and pressure in her head and back. Encouraged by her teacher to direct her attention to the sensation of pressure, she experienced strong negative emotions of terror and hatred and began having recurring images of sexual abuse from her early childhood. While for this woman the response was to discontinue meditation and consult with a psychiatrist, another woman in Miller's study was able to continue mindfulness meditation in conjunction with psychotherapy and medication.

Lindahl (2017) described a similar variability in working with traumatic memories among practitioners of Tibetan Buddhism from the VCE project. Many of these practitioners also reported the surfacing of traumatic memories associated with a release of pressure or tension in a specific part of the body. For some practitioners, the container of practice sufficiently enabled them to explore traumatic and other intense emotional experiences in a way that was not destabilizing. These practitioners often framed their experiences as instances of "purification," which is a central aspect of the preliminary practices of Vajrayāna Buddhism among Tibetan lineages. For other practitioners, the re-experiencing of traumatic memories was too destabilizing, and they tended not to describe their experiences as purification but instead discontinued practice and sought additional psychotherapeutic support.

Many teachers in the VCE study acknowledged the difficulties in deciding how to respond to intense affective experiences. Some described that having a trauma history can make difficult stages of practice more challenging, and that meditators can become "flooded" by traumatic memories to the extent that they become re-traumatized. And although most teachers considered the presence of suicidal ideation a "red flag" that would be best addressed through psychotherapy and not meditation alone, one teacher thought that transient suicidality could arise during the difficult stages of the "insight knowledges" and could be addressed through practice. The duration of the experience and the degree of functional impairment often served as indicators of whether a meditator should seek additional support.

Somatic Changes

A wide range of somatic or physiological experiences has been documented in research on meditation. In the VCE study, practitioners reported sleep changes, appetitive changes, sensations of pressure or tension, pain, thermal changes, somatic energy, and involuntary movements, and similar experiences have been documented in other studies (Kornfield, 1979; Shapiro, 1992; Miller, 1993; VanderKooi, 1997; Chan-Ob & Boonyanaruthee, 1999; Yorston, 2001; Chen et al., 2011; Lomas et al., 2015). Many

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somatic changes were described by Buddhist teachers as expected effects of practice, in particular more intensive or long-term practice. Practitioners also reported that somatic energy—“a type of sensation moving throughout the body or throughout a body area described with language of vibration, energy, current, or other related metaphors”—was often distressing and impairing, especially when prolonged and when management strategies were unknown (Lindahl et al., 2017, Appendix S4).

Experiences of somatic energy are associated with a wide range of valences, appraisals, and responses. In their study of Chinese Ch’an and Pure Land monastics, Chen and colleagues (2011) reported a case of “electricity flowing through my body when meditating” (p. 663). The authors classified this experience as corresponding to the “sacredness” facet of Hood’s mysticism scale. Kornfield (1979) found that somatic energy was described by meditators as frequently occurring in conjunction with “spontaneous” and “involuntary” movements (p. 45), and was framed by some as part of a process of “unstressing” and “energy release” (p. 52). Kornfield, who is also a Vipassanā teacher, characterized these experiences as “common and normal” results of intensive mindfulness and concentration practice (p. 41). He rejected the tendency within Western psychology to offer “pathological interpretations” of such phenomena, arguing this was based on lack of awareness of the “frequency and variety of unusual experiences” found in meditative practice and that such experiences are better understood as part of a “non-linear process of growth in meditation” (pp. 41, 53). In contrast, Shapiro (1992) documented similar experiences of “energy releasing” occurring along with “shaking” among Vipassanā practitioners, but in the context of other disabling symptoms, he described them not as indications of a process of growth but as “profound adverse effects” (p. 64).

In the VCE study, experiences of somatic energy yielded similarly diverse appraisals. Generally speaking, Tibetan Buddhist teachers and practitioners employed resources within their tradition to interpret and work with these sensations, while Zen and Vipassanā teachers and practitioners often drew upon frameworks from outside their traditions, in particular that of “*kuṅḍalinī* awakening.” The Tibetan Buddhist tradition explicitly acknowledges somatic energies, which are understood as connected to the “subtle body” and its system of “channels,” and the tradition has models for working with this energy at various stages of practice (Lindahl, 2017, p. 8). Tibetan teachers in the VCE study as well as in VanderKooi (1997) made reference to *lung* or “wind” (Tib. *rlung*), a bodily energy that is cultivated through advanced practices such as inner heat as part of the process of purification and self-transformation (Lindahl, 2017, p. 4). However, these and other meditation practices can also cause problems if energy begins to “flow” in an “incorrect” fashion (VanderKooi, 1997, p. 40). These teachers indicated that such difficulties could arise as a result of “an improper use of certain advanced meditation practices” or “excess concentration and overexertion” (VanderKooi, 1997, pp. 40–41), for which they may apply the Tibetan medical diagnosis of *lung* disorder (Tib. *srog rlung*) (Lindahl, 2017, pp. 9–10). Such problems are often not trivial and can include psychosis,

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which is why teachers referred to these practices as potent tools for awakening, but also as potentially “dangerous” (VanderKooi, 1997, p. 34).

Some Zen and Vipassanā teachers and practitioners indicated that the lack of a clear framework around somatic energy in their traditions proved to be a challenge as they attempted to manage these experiences that nevertheless arose from meditating. For practitioners, the distress associated with their experience could be compounded when teachers were unable to provide practical advice for managing energy. In multiple cases, practitioners from Zen and Vipassanā traditions looked beyond their tradition to teachers familiar with “*kuṇḍalinī*”—a key concept associated with energy in yogic and tantric traditions from South Asia. *Kuṇḍalinī* experiences are also paradigmatic examples of “spiritual emergencies,” and according to Grof and Grof (1989), must be worked with carefully in order to lead to positive transformation. This understanding has been influential in Western conceptions of meditation-related experiences of somatic energy and has thus likely influenced (indirectly or directly) some Buddhist meditation teachers and practitioners as well, especially in cases where emic frameworks for somatic energy are absent.

Changes in Sense of Self

The sense of self is supported through various conceptual, affective, and embodied processes, and meditation can have various impacts on one or more of these processes. This includes changes in the narrative self and extends to changes in the sense of ownership over thoughts, emotions, and body sensations, or to the sense of agency over actions. In addition, changes in one’s sense of location relative to one’s body and changes in the sense of boundaries between self and world have also been documented. Given the centrality of Buddhist teachings around not-self (Pali. *anattā*) and the selflessness or emptiness of persons (Skt. *pudgala-nairātmya*, *pudgala-śūnyatā*), some of these changes are appraised in relation to normative Buddhist views, values, and conceptions of goals. However, changes in sense of self can also be distressing, destabilizing, involuntary, and enduring, resulting in practitioners seeking alternate clinical diagnoses and support.

Chen and others (2011) reported “out-of-body” experiences, a sense of merging with “being,” or becoming “one with the universe” or the natural world. Although some meditators “rejected the legitimacy” of these experiences, none were reported as challenging, distressing, or impairing (pp. 659–662). Similarly, recent studies of Vipassanā practitioners have documented a decreased sense of ownership over body sensations and sense of agency over actions, changes in location of self relative to the body, and diminishment of the sense of boundaries between the body and the world (Dor-Ziderman et al., 2013; Berkovich-Ohana et al., 2013; Ataria et al., 2015; Ataria, 2015). The meditators in these studies were long-term practitioners who could induce these changes at will or were familiar with them from prior meditation experience; however, this research did not comment on the psychological or behavioral impact of these experiences or appraisals of their meaning or value.

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A different picture emerges from research specifically aimed at investigating challenging, distressing, or adverse effects of meditation. In a study of long-term Vipassanā practitioners, Shapiro (1992) included the report of a meditator who experienced a “brief but powerful experience of egolessness which brought deep terror and insecurity” (p. 65); the practitioner related to the experience as transitory and did not experience persistent distress. Lomas and others (2015) found that 6 of 30 male Buddhist meditators in their study reported “depersonalization,” which they described in “highly negative terms” (p. 857). Summarizing one case study of an “out of body” experience reported as “alienating and disturbing,” Lomas and colleagues noted that “without guidance from a teacher or a *sangha* to help him interpret his experiences, the deconstruction of the self (which is the goal of the practice) was experienced as a frightening dissolution of identity, rather than as a sense of liberation (which the practice is arguably designed to invoke)” (p. 855). While this suggests that a “challenging” or “adverse” change in sense of self is simply one that is inadequately contextualized or understood, these might not be the only criteria that are important in considering whether or not an experience is deemed normative.

The VCE study documented a wide range of changes in sense of self among meditation practitioners, many of which were associated with significant distress, impairments in functioning, or both. Teachers in the VCE study acknowledged that because of their importance in Buddhist theory and practice, changes in the sense of self posed particular challenges for deciding whether to appraise an experience as a normative part of the path or as a potential problem in need of additional support. Many teachers acknowledged that one of the fundamental components of meditation practice was to “destabilize” or “deconstruct” the sense of self, or to experience a “dissolution of self.” However, others identified certain “dissociative experiences,” which they differentiated from valid insights and attributed to improper practice. Still others believed that anticipated, normative experiences from meditation practice were akin to the psychiatric understanding of dissociation and depersonalization. These perspectives are further complicated when one considers that from a traditional Buddhist perspective, genuine insights into not-self can themselves be distressing (Buddhaghosa, 1991; Pabongka, 1991).

Cognitive Changes

Cognitive changes associated with meditation include normative meditation experiences of heightened meta-cognition, increased mental stillness, or changes in worldview (Kornfield, 1979; Pagis, 2010; Chen et al., 2011; Full et al., 2013), as well as impairments in executive functioning (Shapiro, 1992; Yorston, 2001) and delusional, irrational, or paranormal thought and beliefs (Walsh & Roche, 1979; Miller, 1993; VanderKooi, 1997; Chan-Ob & Boonyanaruthee, 1999; Lomas et al., 2015; Kaselionyte & Gumley, 2018). The issue of appraisal is particularly salient with respect to the phenomenology of delusional, irrational, and paranormal beliefs. Clinical research typically views such experiences as evidence of psychosis, especially when they coincide with other changes such as hallucinations, disordered thinking, mania, or disruptive behaviors (Walsh & Roche, 1979; Miller, 1993; VanderKooi, 1997; Chan-Ob & Boonyanaruthee, 1999; Lomas et al., 2015).

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Walsh and Roche (1979) and Chan-Ob and Boonyanaruthee (1999) described delusions of persecution and religiously themed delusions of grandeur, which were accompanied by significant additional phenomenology, including lack of “insight,”² “flight of ideas,” and “loosening of association” (Chan-Ob & Boonyanaruthee, 1999, p. 926), as well as hallucinations, insomnia, and bizarre, disruptive, or violent behavior. In many cases, practitioners were directed to psychiatric treatment (including inpatient hospitalization) and medication.

Qualitative studies tended to capture a broader range of appraisals that demonstrated some ambiguity between delusional beliefs that might be concerning to a meditation teacher and paranormal beliefs that could be appraised as normative. VanderKooi (1997) reported experiences where “everything seemed symbolic and had cosmological dimensions” to the extent that one participant believed her teacher “was God” (p. 36), and Lomas and colleagues (2015) described a practitioner who believed he “was going to be the next Buddha,” a belief he thought “contributed to his breakdown” (p. 855). Two Buddhist teachers interviewed by Kaselionyte and Gumley (2018) described “powers of the mind” such as supernormal hearing or vision, reading minds, and seeing past lives (p. 6), experiences recognized as normative within the Buddhist tradition (Buddhaghosa, 1991). One of the teachers indicated that there was danger in practitioners getting “caught up” in such experiences due to the risk of developing “delusions about themselves and the nature of things” or believing they had become enlightened (Kaselionyte & Gumley, 2018, p. 8)—a concern also identified in Buddhist literature (Sayadaw, 1965; Hsuan Hua, 2003).

Teachers in the VCE and other studies acknowledged that extreme cognitive changes were sometimes difficult to distinguish from religiously normative experiences. While a Tibetan teacher claimed that “advanced meditators need a qualified teacher ... to differentiate between psychotic states and true spiritual visions” (VanderKooi, 1997, p. 42), teachers often acknowledged that they did not have the requisite qualifications to make this assessment. Similarly, Kaselionyte and Gumley (2018) found that teachers varied in their self-assessed ability to differentiate a spiritual experience from a mental health problem. This challenge is not limited to meditation research, however, as there have been various other attempts at establishing differential diagnosis between religious, spiritual, or mystical experiences on the one hand, and delusions or psychopathology on the other.

Approaches to Differentiating Religious Experiences from Psychopathology

This section reviews various previous attempts at differentiating religious, spiritual, or mystical experiences from schizophrenia, psychosis, or psychotic-like symptoms. The criteria offered come from researchers adopting different methodologies, ranging from phenomenology, psychology, and psychiatry (Brett, 2002; Heriot-Maitland, 2008; Parnas & Henriksen, 2016) to proponents of transpersonal psychology (Grof & Grof, 1989; Viggiano

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& Krippner, 2010; Vieten & Scammell, 2015), and also previous reviews on this topic (Menezes & Moreira-Almeida, 2009, 2010). Despite the intuitive assumption that some experiences would be either “religious” or “psychopathological” simply by virtue of their characteristics, research has generally concluded that the core qualities of an experience are not sufficient for making a differentiation and that other criteria must be taken into consideration. These additional criteria can be summarized as referring to (1) individual factors, such as attributes, traits, or qualities of the person, and the impact of the experience on the person; and/or (2) socio-cultural factors that take into account the person’s social situation, cultural background, and current contexts.

Individual Factors

Criteria for differentiating religious experiences from psychopathology based upon the individual undergoing the experience include appraisals of the person’s health, their capacities, and their intentions or attitudes, as well as the subsequent impact of the experience on their functioning or well-being. Both Menezes and Moreira-Almeida (2009; 2010) as well as Vieten and Scammell (2015) included the absence of medical or psychiatric comorbidities among their criteria. Other mental health requirements are described in terms of capacities, such as “intact reality testing,” a “critical attitude,” “psychological maturity,” healthy personality or ego structure, or the ability to induce or control the experience (Miller, 1993; Heriot-Maitland, 2008; Menezes & Moreira-Almeida, 2009, 2010; Vieten & Scammell, 2015; Parnas & Henriksen, 2016). Some capacities may be acquired or trainable. These include attributions to the person’s “relationship to the meditation practice” (Miller, 1993, pp. 176–177) or concerns over inadequate preparation, particularly prior to undertaking advanced practices (Preece, 2011; Lomas et al., 2015). Individual criteria also extend to include identity and worldview. Brett (2002) argued that it is the presence of an epistemic framework that will allow a person to take the “appropriate perspective” toward an experience (p. 336). Thus, religious experiences could be differentiated by their coherence and meaningfulness (Vieten & Scammell, 2015). As Heriot-Maitland (2008) put it, the mystic will have “a *context* to provide meaning for the experience, thus allowing the development of a *structured* appraisal” (p. 317). Many researchers also considered the impact of the experience on the individual, positing that religious or spiritual experiences do not require additional clinical support, are associated with minimal distress and impairment, and promote a sense of meaning or personal growth over time (Menezes & Moreira-Almeida, 2009, 2010; Viggiano & Krippner, 2010; Dein & Littlewood, 2011; Vieten & Scammell, 2015; Parnas & Henriksen, 2016).

Many of these criteria have exceptions, caveats, or contradictions. In terms of a person’s mental health, individuals with no comorbid prior psychiatric or trauma history can still have experiences that they and others do not consider religious or spiritual. Furthermore, a history of psychopathology does not preclude the possibility of having a positive religious experience, as religious experiences and psychopathology can co-occur. In terms of capacities, practitioners could lose their critical attitude regarding the reality of the experience or their control over it and still conclude that it was a religious experience. In

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terms of impact, experiences appraised as religious could still be associated with considerable distress or suffering, including functional impairment. Conversely, while religious experiences are characterized as transient and non-impairing (Menezes & Moreira-Almeida, 2009, 2010; Vieten & Scammel, 2015), psychiatric problems can also be acute and time-limited, and the impact of experiences appraised as religious can last for many years.

Socio-cultural Factors

On account of these challenges, an increasing number of scholars are acknowledging that differentiating religious experiences from psychopathology is possible only when the cultural embeddedness of the experience itself as well as those appraising it are taken into consideration. In this view, a foundational criterion is whether or not a given experience would be accepted as normative within a religious community or is in some other way compatible with the person's cultural background (Menezes & Moreira-Almeida, 2009, 2010; Dein, 2012; Taylor & Murray, 2012). In some cases, the consideration of cultural background will conflict with other prospective criteria such as distress or functional impairment. In particular, Buddhist meditation traditions complicate the picture considerably by framing various types of challenging and even distressing experiences as normative parts of the path, which means that religious experiences cannot be straightforwardly disambiguated from psychopathology simply on account of being positive in valence or impact.

Similar considerations of cultural background significantly informed the 4th and 5th editions of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, including how the relationship between depersonalization disorder and meditation was characterized. The *DSM* considers depersonalization as non-pathological if it was intentionally induced by meditation, stating: "Volitionally induced experiences of depersonalization/derealization can be part of meditative practices that are prevalent in many religions and cultures and should not be diagnosed as a disorder." Nevertheless, there remain further considerations to be applied to each case: "However, there are individuals who initially induce these states intentionally but over time lose control over them and may develop a fear and aversion for related practices" (*DSM-5* American Psychiatric Association, 2013, §300.6, p. 304). This acknowledges the potential complexity of experiences of depersonalization and suggests that the clinician should be alert to the possibility that such experiences may become associated with a loss of control and distress. The recommendation here is that diagnosis should not be made based on isolated features of the experience; rather, it depends on whether the experience is persistent, escapes individual control, and causes distress and impairment. Even if the experience does cause distress, if it is normative or expected and can be addressed adequately within the cultural context (in this case a meditation tradition and practice setting), then the key issue is whether the person requires additional (psychiatric, psychological, or biomedical) support. This determination involves assessing local contexts and resources for coping and recovery as much as it does determining the

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nature of the individual's condition. In either case, assessment includes determining both vulnerability and strengths or resilience factors (Kirmayer et al., 2016b).

Appraisals of meditation experiences are not simple determinations made by a meditation expert in relationship to a straightforward report of an experience. Rather, as with other experiences, appraisal processes are multiple, take place at both intrapersonal and interpersonal levels, and are further embedded in the views and values of the broader society (Kirmayer, 2008, 2015a; Taves, 2009). Meditation teachers, practitioners, and clinicians all contribute to determining which experiences are significant, identifying plausible causal attributions or explanations, and deciding how challenging experiences should be managed. Clarifying the overlapping set of forces that shape meditative experiences is crucial in order to advance an ethically sound and pragmatically effective approach to assessing and responding to challenges.

Situating Meditation-Related Challenges in Context

Decision-making and attributions for meditation-related challenges have tended to overemphasize the characteristics of individual practitioners and often insufficiently attend to embeddedness of both the meditator and other decision-makers in larger social contexts, including relationships to practice communities, authorities, institutions, traditions, and cultures—all of which influence appraisals of experiences and responses to them. With examples from the VCE study and other research, this section illustrates how socio-cultural factors impact appraisals and responses of both meditation practitioners as well as meditation teachers and clinicians. These dynamics also highlight why general or universal recommendations for differential diagnosis are not possible. Rather, the unique situatedness of each meditator must be considered on a case-by-case basis.

Meditator-in-Context

A meditator's social positioning and worldview can impact how they view and respond to their own meditation-related challenges. For example, appraising challenges as part of the path and getting through such challenges without resort to outside help confers the higher social position that comes from spiritual attainment. Such incentives could increase the desire to appraise a challenging experience in spiritual terms and avoid psychological or medical treatment, especially medications, which, by being biologically based, would associate the experience with a biological disease state.

Practitioners in the VCE study held a wide range of attitudes toward supplementing practice with psychotherapy or medication. Some did not believe that their challenges warranted psychological support or intervention; others were concerned that going to a psychologist would not have been helpful because a psychologist would not understand their experiences as part of a religious path and would diagnose them with a mental illness. Some practitioners found talking with a therapist to be helpful when their

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experiences were normalized or validated. One of the variables that determined how well an encounter went between a meditation practitioner and a psychotherapist was the therapist's ability to understand the worldview and belief system of the practitioner. Some clinicians and many practitioners acknowledged that certain meditation-related problems warranted not only psychotherapy but also medication (cf. Kaselionyte & Gumley, 2018, p. 10). In many cases, medications were reported as helpful in allowing practitioners to stabilize and overcome distress and functional impairments. However, some meditators associated use of medications with a sense of shame, stigma, or loss of status within their meditation community.

These data highlight the tension between social values and medical recommendations, as avoiding medication may confer social status and spiritual attainment, but may also increase the risk of chronic disability from untreated illness (Judd, 1997; Drancourt et al., 2013; Santesteban-Echarri et al., 2017). While there is empirical evidence of poor outcomes when biomedical frameworks are not followed, there is no corresponding empirical evidence for positive outcomes when normative, non-pathologizing frameworks are followed (Menezes & Moreira-Almeida, 2010). More research is needed to provide accurate estimates of both risks and benefits for each choice.

Understanding the Context of the Assessment of Meditation Experiences

The social embeddedness and positioning of those who assess meditation experiences (e.g., meditation teachers, clinicians, or psychiatrists) impacts the decision-making process. For example, a teacher's educational background or training is likely to influence their appraisals. VanderKooi (1997) found that teachers whose own training and approach had been influenced by psychology were more likely to consult with mental health professionals when students encountered severe psychological problems and believed that "pushing students to 'break through' does not facilitate integration of an enlightenment experience and can damage students who are psychologically fragile" (p. 42). Conversely, both the VCE study and Kaselionyte and Gumley (2018) found that some teachers without clinical training acknowledged their limitations in identifying or responding to destabilizing experiences that could be indicative of mental illness. Teachers in the VCE study also reported that experiences that require a great deal of time and attention are likely to be appraised as problematic. Thus, the decision to send a meditator home from a retreat or to a hospital could be based not only on the nature of the experiences of that meditator, but also on the resources available, including time, training, and staff.

The teacher's social position must always be considered as a potential causal influence on their appraisals, particularly on their causal attributions. Two common causes of meditation problems given by teachers in the VCE and other studies were the meditator's "incorrect practice" and "incorrect response or attitude." Although both VanderKooi (1997) and the VCE study found that teachers cited a meditator's "excessive effort and striving" as a common source of problems, there was generally little consensus among

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meditation teachers regarding which dimensions of practice were problematic. VanderKooi (1997) reported that for Theravada Buddhist teachers, problems arise “when concentration is not balanced with adequate mindfulness,” whereas Zen teachers attributed difficulties to “incorrect posture and breathing,” and Tibetan teachers attributed energy imbalances in particular to “an improper use of certain advanced meditation practices” (p. 40). These attributions have also been made in clinical case studies. Chan-Ob and Boonyanaruthee (1999) declared that “meditation, regardless of kinds or schools, has never produced psychotic symptoms provided it is practiced in the right way”; however, “wrongly practiced meditation causes more stress,” leading to sleep loss, which, in their view, is the real cause of psychosis (pp. 927–928).

Teachers have also attributed the cause of meditation-related challenges to the meditator’s “incorrect” attitude or response, which therefore can be remedied by the “correct” response. For example, some teachers thought that extreme experiences, including psychosis, could arise because of “overidentifying with NSC [non-ordinary states of consciousness] and being unable to disidentify and let go” (VanderKooi, 1997, p. 40). Similarly, Kornfield (1979) suggested that “periods of strong fear and insecurity ... are usually resolved by surrender, by fully experiencing them” (p. 54). Such attitude-based attributions also imply that any enduring difficulty or distress is a result of insufficient acceptance. While some practitioners in the VCE study reported that an experience became less difficult or distressing when it was accepted, others noted that acceptance resulted in their symptoms being prolonged unnecessarily when some sort of intervention would have been more appropriate. Further, the notion that with the right attitude any adversity will subside creates a situation in which practitioners may be found deficient and blamed for their own suffering (Kirmayer, 1990).

Teacher Social Positioning and Victim-Blaming

The tendency toward victim-blaming—or more generally, to attribute causes to dispositional traits rather than to external conditions—is a well-documented attribution error (Heider, 1958) and is further influenced by social identity, gender, affective reaction, and personal and financial investments (Bal & van den Bos, 2010; van der Bruggen & Grubb, 2014). This victim-blaming tendency has been well documented in other contexts, and often serves the function of deflecting responsibility away from incumbent power structures. For example, reports of “shell-shock” (later called Post-Traumatic Stress Disorder or PTSD) were attributed by military doctors to soldiers’ preexisting psychological instability or “weak personalities” (Roberts-Pedersen, 2012), and sexual assault is often causally attributed to traits or behaviors of the victim (promiscuity, intoxication) rather than to the perpetrator (Davis et al., 1991; Ullman, 1996).

As described in both the VCE study and in other studies, when teachers were interviewed or when teachers’ attributions were mentioned by practitioners, it was frequently the case that they attributed meditation-related difficulties to practitioner-level factors or to vague, difficult-to-quantify, dispositional deficiencies of the meditator (e.g., preexisting psychological vulnerabilities, unstable psyches, trauma histories, perpetuation of ego-

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structures, inadequate preparation or understanding, incorrect practice, insufficient acceptance of an experience, or insufficient surrendering or letting go). Placing exclusive emphasis on individual attributions can serve to deflect responsibility and blame to the meditators and away from the teachers, practices, or other aspects of the meditation culture. Since such attributions are often made retrospectively, after a positive or negative outcome is known, these attributions allow for negative outcomes to be attributed to the meditators, while positive outcomes can still be claimed as benefits of the meditation practice. This selective attribution process constitutes a “secondary victimization” (Symonds, 1980), which increases trauma-like symptoms and prolongs recovery time (Davis et al., 1991; Ullman, 1996). Victim-blaming also discourages disclosure, which contributes to past, current, and future underreporting of challenging or negative experiences (Ahrens, 2006).

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Practitioners consistently reported that finding helpers who supported their goals, expectations, and values around meditation was critical for navigating meditation-related challenges. Values-based and person-centered approaches in mental health offer ways to think through the negotiation of meaning in the context of challenging meditation experiences (Jackson & Fulford, 2002). A “person-centered approach” is contrasted with a disease or disorder-centered approach in that it aims to address the needs of the person (including the totality of the person’s health, both illness- and wellness-related aspects), as engaged *by* the person (with both patients and clinicians extending themselves as full human beings), *for* the person (assisting the fulfillment of the person’s aspirations and life project), and *with* the person (in a respectful and empowering relationship with the person who consults) (Mezzich et al., 2010; Cloninger & Cloninger, 2011; Kirmayer et al., 2016b). With respect to meditation, this approach emphasizes the practitioner’s agency and autonomy in deciding when meditation-related challenges need additional support through social, psychological, or medical interventions. From this perspective, what constitutes health and well-being, as well as what has ultimate value for the person, is determined through dialogue with them and by consideration of their lifeworld and social context; it is not simply assumed or imposed by others.

Clinically, distinguishing between normative or desirable experiences and psychopathology depends on understanding the individual’s social and cultural contexts—an approach central to cultural and person-centered psychiatry (Kirmayer et al., 2016a, 2016b). This cultural context includes identities, roles, values, goals, norms, and expectations, some of which are explicit but many of which may remain tacit or implicit until they are highlighted by a challenge or conflict. Thus, assessing the meaning of unusual or distressing experiences requires not just information about explicit cultural norms and values, but also modes of dialogical engagement that allow the individual and others to explore and negotiate the meaning of experiences (Rashed, 2010). In the mental health literature, the conditions for this are sometimes framed as “cultural safety” and

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clearly depend on addressing hierarchies of power that may result in the silencing of challenging or divergent perspectives (Kirmayer et al., 2016a).

Increased recognition of the importance of cultural context has also shaped the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. In an attempt to provide a more culturally-sensitive and person-centered approach to clinical diagnosis, the *DSM-5* Cultural Formulation Interview gives concrete and detailed methods for exploring the embeddedness of both the client and the provider in multiple overlapping cultural contexts with multiple social identities, values, and priorities, all of which interact with illness experience and treatment trajectories that change over time and circumstance (Lewis-Fernandez et al., 2014, Adeponle et al., 2015). This approach has the potential to address the challenges of differential diagnosis of meditation-related challenges by situating individual experiences in their personal and social contexts (Kirmayer, 2015b).

Instead of focusing exclusively on symptoms, a person-centered approach attempts to contextualize meditation-related challenges by relating them to relevant social and cultural frameworks, including religion and practice setting. Experiences that are not distressing or functionally impairing may be more likely to be framed adequately in terms of a religious worldview. But even distressing or impairing experiences may also be accepted by a community as expected challenges or even as positive indicators of progress along a religious path. This renders the use of local norms for differential diagnosis more complicated. In particular, the fact that a range of challenging, distressing, and impairing experiences can be considered part of the path across Buddhist traditions further complicates attempts to determine when a challenging experience is normative and when it is considered a problem requiring additional support or intervention.

Challenges to a Person-Centered Approach to Meditation in the West

The person-centered approach is one of the dominant paradigms in clinical psychotherapeutic settings. However, this privileging of the individual's experience and values is sometimes at odds with other institutional commitments and authority structures, including those of religions. Given the plurality of discourses concerning meditation—especially in the modern West, where it is presented as scientific, secular, or religious depending on context and intent—these commitments may not always be clear. Some contemporary meditation organizations may imply they are following a person-centered approach, when in fact they share more characteristics with institutionalized religions, where key values and beliefs (such as the purpose of life, definitions of health and well-being, the nature or purpose of human existence, or the causes of suffering and happiness) tend to be predetermined, immutable, and not open to individual interpretation. These religious commitments may often be tacit or presented behind a veneer of secularity, and may lead to conflict for those who assume that meditation is primarily a means to reach their own, preexisting goals, rather than having their goals and values challenged and changed. The individual reporting an adverse experience may

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then constitute a challenge to the authority of the religious institution and evoke responses that aim not only at managing their distress but also at containing or limiting the threat they represent to the institution. Examining these social and political processes of dealing with challenges to collective norms is an important, but relatively neglected, dimension of understanding meditative practices and traditions.

Conclusion

In this chapter, we have introduced a typology of challenging experiences associated with the practice of meditation. We have also identified some of the ways in which experiences are appraised by practitioners, teachers, clinicians, and researchers. The current data suggest that establishing a clear differential diagnosis between a “normative” meditation experience and “psychopathology” might not be straightforward. As with psychiatric diagnoses, the purpose is to offer guidance or intervention to people faced with difficult or troubling experiences. Recognizing the forms of culturally valid and non-pathological experiences is basic to spiritual and religious competence for clinicians, and it is equally important for meditation teachers to recognize that not all meditation-related experiences have to be viewed as a part of the path and responded to only by means of continued practice. Instead of aiming to establish criteria for differential diagnosis, practitioners, teachers, and clinicians may be better served by focusing on the practical questions: (1) whether the experience warrants additional support or intervention; and (2) what type of support or intervention might be most appropriate.

Among meditation teachers, the most widely agreed upon criteria for pursuing additional support are similar to the criteria for clinical significance: degree of distress and functional impairment, duration, degree of control, and relationship to the client’s and the tradition’s cultural norms. In addition to these criteria, cultural psychiatry and psychology emphasizes the importance of considering the social contexts, positions, identities, relationships, and power dynamics of the practitioner and others, including any authorities—such as a clinician or meditation teacher—who are involved in the decision-making process. Elaborating this broader contextual view requires further research on the social and cultural contexts of meditation and the looping effects between individual expectations, embodied experiences, and social responses.

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Notes:

(1.) For adverse effects in the context of Transcendental Meditation (TM) see Kennedy (1976), Otis (1984), and Castillo (1990). For a summary of practice-related challenges in Abrahamic religions, see Fisher, this volume. For more information on meditation-related challenges in Ch'an and Zen Buddhism, see Ahn, this volume.

(2.) Lack of insight in this context refers to the individual's lack of awareness that they are ill (Kirmayer et al., 1998).

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