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Meditation and psychosis. The comparison of the current knowledge in the light of scientific evidence and the experience of an Eastern meditation teacher

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Summary

The aim of the study was to compare the current knowledge on the relationship between the use of meditation techniques and the occurrence of psychosis with the experience of an Eastern meditation teacher, Osho Rajneesh. While searching the PubMed database using the keywords "meditation AND psychosis" 72 research articles were obtained, of which only 17 fully corresponded to the assumptions of the work. They included the case reports of the patients, as well as meta-analyses, and review articles related to both the positive and negative influence of meditation practices on mental health. Additionally, the information contained in 3 books was used. The etiology of meditation-induced psychotic episodes is not clear given the frequent presence of many coexisting factors including fasting, sleep deprivation, or a positive psychiatric history, as well as the limitation of the methodology. In the analyzed studies, only patients who did not meditate in clinical conditions were reported. The analysis of these cases indicates that the risk of a psychotic episode was associated with excessively long practice and lack of adequate supervision. The comparison of current scientific knowledge with the experience of the Eastern meditation teacher made it possible to draw attention to rarely described in literature risk factors of the development of psychosis, which include "specific traits" of the practitioner's attitude. One of its fundamental elements is an incorrect understanding of meditation as a task to perform, instead of an open, passive, and accepting attitude of observing the external and internal world.

Key words: meditation, psychosis, mindfulness

Introduction

Various meditation techniques have been known and developed in the cultural areas of the so-called East since ancient times. Originally, they served people in the sphere of spirituality, to achieve "enlightenment" – the state of mind characterized by an overwhelming sense of peace and bliss. In recent decades, science has also noticed the beneficial effects of their practice which has been reflected mainly in the domain of psychiatry and psychology, mostly in the form of the development of numerous trends in cognitive-behavioral therapy of the third wave. The most important ones include: mindfulness-based cognitive therapy (MBCT), acceptance and commitment therapy (ACT), compassion-focused therapy (CFT), and dialectical behavior therapy (DBT) [1]. Such diversity partly results from the fact that mindfulness, on which they are based, is a broad term. As indicated by Khoury et al. [2], it has both a cognitive and affective dimension and it can be assigned such meanings as: (a) self-regulation of attention, (b) decentering (however, not in the Piagetian sense, but as redirecting thinking about one specific thing while only paying special attention to one particular trait, towards a more open attitude of noticing other important characteristics as well), (c) awareness of sensations, thoughts, and emotions, (d) openness and acceptance towards of all inner experiences with calmness, (e) non-reactivity and non-judgement, (f) observing and describing, (g) equanimity, (h) kindness, (i) compassion [2].

One of the main promoters of the use of methods rooted in Eastern traditions in Western medicine is Jon Kabat-Zinn, who for the first time applied therapy based on mindfulness meditation in 1979 at the Stress Reduction Clinic founded by himself at the University of Massachusetts. The procedure developed by him, devoid of religious elements, was called mindfulness-based stress reduction (MBSR) and was created by combining ancient meditation, hatha-yoga, and psychoeducation within an eight-week program of meetings and collective exercises. Thanks to many clinical tests proving the effectiveness of this type of technique the paradigm shift was inevitable; nevertheless, the implementation of Eastern meditation in the Western context entailed the need to address the previously existing traditions of understanding this phenomenon.

Originally in the Western world the term "meditation" referred to the conceptual pondering on a given topic or question, mainly on the basis of philosophy. Under the influence of Christian mysticism, however, also an opposite understanding emerged, referring to non-discursive prayer based on concentration or mindfulness. The second way resembles the Eastern approach, in which this phenomenon not only does not engage the thought process but strives to eliminate it. It should be noted that such a dichotomous approach to the problem is a certain simplification, because in fact meditation is a phenomenon as common as spirituality itself, and within the traditionally distinguished "Eastern" and "Western" approaches, many historical trends and schools should be distinguished [3]. Nevertheless, this is beyond the scope of this paper, in which we will present the phenomenon in a more simplified way, because the division of meditation practices in terms of the nature of mental activity has clinical implications. The practitioner's suboptimal approach may be related to the occurrence of acute psychotic episodes or exacerbation of an existing one in the form

of a more pronounced manifestation of psychotic symptoms. This is not simply an issue of improper implementation of Eastern techniques on Western grounds, because many Buddhist schools in their textbooks have drawn attention to the disorders called "demonic states" [4].

The aim of this article is to draw attention to the rarely discussed in the literature and at the same time poorly understood issue of the relationship between meditation and psychosis. The authors wish to introduce knowledge about the relationship between the use of meditation practices and the manifestation of psychotic symptoms based on case reports and currently available data, also attempting to explain the described problem by referring to the knowledge grounded in the tradition of the chosen spiritual teacher.

This literature review was conducted using the PubMed full-text medical database. To identify articles thematically related to the discussed problem the following keywords were searched: "meditation" and "psychosis". On this basis, 72 publications were analyzed, of which only 17 corresponded to the strict assumptions of the work. Only full-text publications in English from the last 50 years were taken into account. Moreover, the information contained in 3 books was used, of which 2 were the collected statements of Osho Rajneesh, and 1 was an academic study on the issues of the adaptation of zen philosophy into the Western cultural matrix.

Results

Various constellations of phrases mentioned above made it possible to obtain 72 articles, of which only 17 were finally selected and the remaining ones were rejected due to insufficient thematic matching to the accepted issues of the work. The case reports [5] and meta-analyses [6] on the issue of meditation-induced psychosis indicate the lack of clear correlation between meditation practices and an episode of mental illness both due to the limitation of methodology and coexisting factors. The attention is drawn mainly to the positive psychiatric history, fasting, sleep deprivation and simultaneously experienced stress due to family and professional reasons [1, 7]. However, the presence of these factors does not directly determine the risk of the development of psychosis, because, according to the available studies, they were found in 50% of cases [6]. Undoubtedly, the duration and conditions in which the meditation is performed also have a significant impact on the occurrence of possible psychological damage. Kuijpers et al. [7] present a case of a 24-year-old man, who took part in "unguided and intense sessions", while Joshi et al. [5] report about a patient, who devoted even up to 18 hours a day to meditation, over a period of 20 days. Similarly, a female patient described by Goud [8] meditated even up to 14-18 hours a day for 4 years prior to hospitalization, despite the guru's instruction to meditate twice a day for 20 minutes [8].

It is important to note that in these three cited cases medical indications for meditation are not mentioned and therefore, it can be presumed that the patients decided to start the practice on their own to improve their well-being or spiritual development. Moreover, all of the cases that Sharma et al. [6] included in their meta-analysis, in a total number of 28, referred to the people that did not meditate in clinical conditions, but were brought under clinical care after an occurrence of behavioral disorders, and

then were retrospectively featured by individual authors. Patients included in the study used various meditation techniques, such as transcendental meditation, mindfulness, zen, or Qigong [6].

To better understand the differences between these individual types, two main categories of meditation are often distinguished: "concentration" meditation, which includes transcendental meditation, and mindfulness meditation [1, 8]. In this article, we also use this classification, because there are reasons to associate psychotic episodes with transcendental meditation, or rather with the type of activity that characterizes it, i.e., with a tendency for concentration, as opposed to mindfulness meditation, which seems safer in this respect, also in the treatment of psychoses [1, 10]. However, it should be noted that in contrast to the hours-long practicing of the techniques of transcendental meditation that was used by the patient featured by Goud [8], it has been proven that the interventions based on transcendental meditation are also safe and effective, as long as they do not last longer than 20 minutes a day [9]. Nevertheless, given the reports of possible harm, some clinicians may believe that psychotic patients should not be invited to meditation sessions, especially if they have previously experienced in their practice the distressing symptoms that might have been induced by meditation.

This topic has been controversial and debated for a long time. However, a distinction should be made between short-term discomfort and long-term adverse effects. The latter can be defined as "sustained deterioration that is caused directly by the psychological intervention" [11, p. 2]. The classic adverse effect is depersonalization and the unlocking of repressed traumatic memories. Meditators may see lights, and experience spasms as well as involuntary movements [1]. Serious complications occurring as a result of meditation can include: an acute psychotic episode, including an episode of schizophrenia, an episode of mania with psychotic symptoms, and psychotic symptoms in the course of schizoaffective disorder [6]. It seems that in sensitive people the risk of acute experiences is higher, especially at the beginning of meditation practices [12]. The available literature shows that they are accompanied by complex neurochemical changes in the brain [13], as well as increased blood flow in such regions as the prefrontal cortex, thalamus, hypothalamus, hippocampus, and cingulate gyrus [14, 15]. There is a clear resemblance between temporary deregulation of the prefrontal cortex recorded during altered states of consciousness occurring sometimes during meditation [16] and patterns of synaptic connectivity found in schizophrenic patients [17]. Although the relationship between the changes in the brain and the occurrence of symptoms of mental disorders is unquestionable, from the clinical point of view determining the risk of their occurrence on this basis in an individual patient seems to be impractical. Given the availability of neuroimaging equipment, as well as the nature of the work of most clinicians, a more appropriate method for evaluating and qualifying patients for the use of meditation techniques should be based on psychological rather than neurobiological criteria.

Discussion

Given the variety of meditation techniques, which may lead to psychotic episodes, as well as the ambiguity of relationships between risk factors, based on the experience of the clinicians and spiritual teachers, one variable seems to have a decisive impact on possible undesirable side effects and it is the attitude of the patient. By the term "attitude" we understand here: (a) the degree of involvement in the conducted intervention, which is related to both the willingness to use it for a potentially long time as well as the mental effort put into it; (b) the ability to correctly implement the instructions of the one leading the meditation and/or the obtained information about it. Based on this definition it is easy to understand that the more approving and active the patient's attitude is, the greater their tendency to devote an inappropriately large amount of attention and time to meditation, which may be a possible risk factor. It also takes into account the influence of different techniques, and – which is indirectly related – different ("Eastern" and "Western") ways of understanding meditation itself.

We will use the teachings of Osho Rajneesh to present an "Eastern" perspective. In his statements, he presented probably the most comprehensive and approachable theory of how meditation works, taking into account its various types and conditions affecting both the success and failure of practices. We are aware of all the controversies that are associated with his person; however, we found the content contained in the selected texts to be valuable. Therefore, without denying any allegations that can be made against him or the organization he created, we would like to focus solely on the substantive analysis of the quoted statements.

Osho, as a spiritual teacher from India, obviously presented a typically Eastern point of view; nevertheless, he understood well cultural differences that affect the psychological structure of a man. Being the author of many meditation techniques himself, however, he seemed to base them on mindfulness meditation, understood as "embracing all kinds of intrapsychic experiences, not avoiding but instead engaging in >>kind observing<< of both unpleasant and pleasant thoughts, feelings, somatic sensations, and >>letting go<< of them" [1, p. 2], because all of them are supposed to lead to the achievement of this state. He contrasted this understanding with transcendental meditation, which: "has nothing to do with meditation" [18, p. 321], because, like the incorrect use of mantras or any other technique, it comes down to the concentration of attention. Meanwhile, as he argued, "[meditation] is not concentration, but relaxation". Therefore, it is a fundamental mistake to start the meditation practice as another task to be performed, which comes down to trying to control the flow of thoughts and sensations in order to eliminate them. The correct approach, however, should be based on an open and passive attitude of observing the inner and outer world, and the role of each technique should only be to support the practitioner in order to achieve this state: "observe – do not try to stop anything, do not go against the mind" [18, p. 315].

Despite the right attitude, the sensations that arise during the meditation might be unpleasant, as extensively documented by Prof. Willoughby Britton, a psychiatrist, neuroscientist, and practicing Buddhist. She initiated the scientific project "The Dark Night Project" [19], in which she interviewed many experienced meditation practitioners and

teachers. In this way, she collected data on difficult experiences and bodily sensations that appear during intensive meditation. Osho was also aware of their occurrence: "you will have to face monsters and come face to face with your own unconscious" [18, p. 200]. But when meditation-induced sensations become unbearable, he recommends discontinuing the practice and trying different methods: "it applies to all of the meditation techniques, […] if you feel uncomfortable, or the experienced feeling will be unbearable, stop the meditation and try other methods" [18, p. 219]. For as he warned: "if you honestly make an effort to >>only sit<<, you can truly go mad. Only because people are not honest in their efforts, madness does not happen very often" [20, p. 74]. According to Osho, the source of this "madness" are layers of suppressed feelings: "you carry everything inside you – anger, attitude towards sex, violence, greed" [18, p. 52]. For this reason, he did not recommend beginners, especially people from the Western culture, to start with sitting meditation (zen, Vipassana, classic mindfulness, etc.) because "the more you try to just sit, the more movement you feel inside" [20, p. 73]. In other words, he considers it dangerous to redirect the attention of a human, who has been focused on the outer world till now, to his psyche, carried out in an incorrect way. To remedy this, he suggested using "dynamic meditation" at the beginning, which was supposed to lead to "catharsis". It combines hyperventilation, performing uncoordinated, impulsive movements, screaming, laughing, singing, using the "hu" mantra, and only then freezing and "rejoicing" [18]. At the same time, he repeatedly emphasized the importance of the presence of a guide (teacher, psychotherapist), who is able to recognize the meditator's problems and properly correct his wrong attitude: "only the master can be >>flexible<<, they can change everything" [20, p. 88], unlike self-study from books. He can also be the first, even before the meditator himself, to identify the symptoms of the coming psychosis. These certainly include some forms of altered (extraordinary) states of consciousness that occur during meditation. They are known to experienced meditation teachers, as Lois VanderKooi [21] has exhaustively demonstrated, including among the alarming symptoms and attitudes connected with different states of consciousness: (a) an obsession about different states of consciousness, (b) more negative, alarming, or strange different states of consciousness, (c) fear of madness, (d) disordered behavior, (e) emotionally disconnected schizoid states.

Conclusions

The positive effects of meditation in the treatment of many different mental and psychosomatic disorders have been well documented, but the relationship between meditation and psychological adverse states is less clear. Nonetheless, based on the experiences of meditation teachers such as Osho, as well as available scientific research, it is possible to formulate risk factors for a psychotic episode related to the meditator's attitude. These are: (a) excessive involvement of the patient, manifested in many hours of performing exercises given to him, or in a different way; (b) incorrect understanding of meditation, as a task to be performed, and not an attitude towards the outer and inner world, combined with focusing on one's thought process and distressing sensations, if they appear; (c) signaling, especially at the beginning of meditation, the rush of

thoughts and sensations; (d) first-time use of meditation techniques in a person, who was not previously introspective and/or had never undergone psychotherapy before; (e) practicing on one's own or in a group without a supervision of a teacher/psychotherapist, especially without prior thorough training.

It should be noted that these factors are largely approximate and discretionary. We hope, however, that they might become a guideline for psychotherapists who use meditation techniques in their practice. The question of how exactly their occurrence translates into the risk of a psychotic episode needs further research, although it can be initially assessed that the detection of one or part of them will not necessarily translate into a high risk of harm. For example, even such a disturbing symptom as hallucinations does not have to precede psychosis, as long as the patient maintains the correct attitude, i.e., passively observes them without concentrating on their content, does not let them take over or does not fight them: "The mind will try many different tricks, it will create hallucinations, dreams […]. If you endure this, if you don't give up […]. You won't experience stupor, hallucinations, dreams or thoughts" [18, p. 278]. It is believed that the mechanism of the therapeutic effect of meditation in patients with psychotic disorders lies exactly in adopting such an attitude, i.e., maintaining a passive, accepting observation of psychotic symptoms, which results in separating them from Self leading to the perception that they are temporary and do not have to reflect the reality [22]. Therefore, it is crucial to maintain conscious control over the whole process: "while meditating, you can stop at any moment" [20, p. 193].

From these clues emerges a picture of a mature personality, a meditator, who is self-aware enough to correctly recognize their mental state. As Epstein and Lieff [12] indicate, patients susceptible to experiencing psychosis during meditation are people with poorly developed ego, using primitive defense mechanisms such as denial, projection, or regression. Nevertheless, it should be noted that in the case of intense practice, Osho admits that "either madness or meditation will happen" [20, pp. 108-109]. While this relates to its ultimate, spiritual goal of "enlightenment", which demands a significant amount of dedication and practice, one should be aware that a possible change in life meditation can bring about, is always described as something revolutionary. According to the authors of this study, clinicians should take into account the risk of over-enthusiastic acceptance of the presented methods by the patient and warn about using them independently for excessively long periods of time, especially exceeding an hour a day. It is also worth conducting psychoeducation, which takes into account the possible side effects of meditation so that if they occur, the patient is mentally prepared and does not experience overwhelming anxiety. On the other hand, in special cases, when there is a high risk of a psychotic episode, it is worth considering withdrawing from the use of meditation techniques or postponing them until, as a result of thorough preparation, it is certain that the risk of psychosis has significantly decreased.

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