



Adverse Meditation Experiences: Navigating Buddhist and Secular Frameworks for Addressing Them

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Abstract

The intent of this article is to stimulate a conversation and encourage interdisciplinary discussion and dialog between “secular” and “Buddhist” camps around the notion of adverse psychological experiences that might occur in the context of meditation practice and training, be that as part of a day-to-day practice or in the context of a residential and intensive retreat. Depending on the context, there are significant differences in the way that such experiences are made sense of and, as a result, there may be significant variations in tradition-specific accounts of how to manage such experiences. In each context, implicit foundational values (about, for example, what counts as mental health, or the goals of meditation practice) may lead to very different accounts about what counts as harmful or helpful, and therefore about what is an appropriate course of action. For those teaching meditation, either in secular or religious contexts, this has clear ethical implications—how are the best interests of the student served? This paper will explore examples of this tension by comparing and contrasting accounts about adverse meditation experiences from Buddhist and secular perspectives. A case will be made for a dialogic, mutually engaged, and supportive relationship between Buddhist and secular approaches to adverse meditation experiences.

Keywords Mindfulness · Buddhism · Adverse meditation experiences · Cross-cultural psychology · Secular · Religion

Introduction

There is a small but accumulating body of research suggesting that sometimes people engaged in meditation may experience adverse (i.e., psychologically distressing or disturbing) psychological effects. This distress can be momentary or, in more serious cases, lasting, and with long-term ramifications. These experiences may occur in religious contexts, such as during Buddhist meditation retreats, or in secular contexts, such as during practices associated with mindfulness-based interventions (MBI).

Depending on the context, there are significant differences in the way that such experiences are made sense of and, as a result, there may be significant variations in tradition-specific accounts of how to manage such experiences. For example, a psychiatrist trained in Western allopathic medicine may judge that the distress is symptomatic of mental illness exacerbated by meditation, and

suggest that the person stop meditating. A Buddhist teacher, on the other hand, may understand the distress as a sign that the meditator is progressing through stages of insight towards liberation of suffering and suggest more meditation or auxiliary practices as a way of moving through this stage.

In each context, implicit foundational values (about, for example, what counts as mental health, or the goals of meditation practice) may lead to very different accounts about what counts as harmful or helpful, and therefore about what is an appropriate course of action. For those teaching meditation, either in secular or religious contexts, this has clear ethical implications—how are the best interests of the student served? This paper explores examples of this tension by comparing and contrasting accounts about adverse meditation experiences from Buddhist and secular perspectives. A case is made for a dialogic, mutually engaged, and supportive relationship between Buddhist and secular approaches to adverse meditation experiences, using an example of an approach that weaves these different maps together. This topic is important for the mindfulness practice and research community because it represents another dimension for consideration about best practice, particularly when de- and re-contextualizing meditation techniques derived from spiritual traditions.

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Contemporary Research and Discussion of Adverse Meditation Experiences

Although there is extensive research literature demonstrating the benefits of meditation, less attention has been given to the fact that it is fairly common for meditators to have disturbing or unsettling experiences (Lindahl et al. 2017). Discussion about it in psychological literature is on the increase. Until very recently, most accounts have largely been based on very small study sample sizes or on individual accounts. However, first results from a long-term systematic study by Lindahl et al. (2017) suggested that meditation-associated challenges are fairly common across different types of meditation and called for greater investigation into these experiences and support for people having them.

Lindahl et al. (2017) interviewed more than 100 subjects who had particularly difficult or challenging meditation experiences. The first stage of this study focused on practitioners and experts (i.e., Buddhist meditation teachers) from Theravada, Zen, and Tibetan Buddhist traditions practicing in Western contexts who had experienced some kind of meditation-related challenge.

Lindahl et al.'s (2017) study focused on practitioners of meditation within Buddhist contexts and not on secular mindfulness-based interventions (MBIs). However, they noted that some participants reporting challenging experiences were engaged in practices similar to MBIs:

A number of participants also reported challenging or difficult experiences under similar conditions as MBIs, that is: in the context of daily practice; while meditating less than 1 hour per day, or within the first 50 hours of practice; and with an aim of health, well-being or stress-reduction. (p. 15)

This suggests that the findings of Lindahl et al.'s (2017) study are relevant and applicable to the field of secular mindfulness. Meditation practices, particularly ones associated with mindfulness-based programs, have become increasingly popular in Western secular psychotherapeutic contexts, so investigation into adverse meditation experiences is important. Academic research in mindfulness has also grown exponentially in recent years, but increasingly, this has been disembedded from the predominately Buddhist contexts from which it emerged (Valerio 2016).

Some of the factors influencing adverse meditation experiences are related to meaning-making contexts and narratives, so this issue of contextualization is important. Findings of the Lindahl et al. (2017) study are generally consistent with previous research about adverse meditation experiences. After an initial brief summary of some of the research in this area, this essay will focus in on contextualizing narratives, and how these might moderate or exacerbate adverse meditation

experiences. In this article, the focus is on Buddhist practices, but it should be remembered that the issues discussed here could be pertinent to any practices embedded, either currently or historically, in any non-secular context but applied in secular and/or clinical settings.

Accounts About Adverse Experiences in Buddhist Traditions

As Lindahl et al. (2017) noted, the existence of adverse meditation experiences is acknowledged across Buddhist traditions. In Theravada Buddhism, the phenomena are dealt with in some detail in the *Visuddhimagga*, Buddhaghosa's fifth century treatise on the "Path of Purification" towards enlightenment, where seven progressive stages of meditative insight are described. Integral to this path of insight are experiences ranging from intense bliss to strong distress (Buddhaghosa and Ñāṇamoli 1997).

In Zen traditions, the term *makyo* is used to describe hallucinations or other unusual mental and physical phenomena that may arise as a "side effect" of meditation (Austin 1999). Vajrayana Buddhist traditions such as Dzogchen and Mahamudra use the word *nyams* to describe some of the unusual visions, hallucinations, or physically strong feelings that can accompany meditation practice (Gyatso 1999). These can be both positive and negative. For example, Dudjom Rinpoche (2005) described some of the possible negative effects as "various frightening magical apparitions ...in experiences or dreams," "intense suffering for no apparent reason," wrong views towards one's teacher and a wish to abandon the practice, a feeling that "you are about to go crazy" (p. 56), and unpredictable and unpleasant external events, such as being attacked by robbers or thieves and getting a disease.

A comprehensive account of different traditional Buddhist taxonomies and remedies for adverse meditation experiences is not within the scope of this paper. However, even this cursory glance brings into focus some important points relevant to this discussion. From these examples, it is clear that across Buddhist traditions there is some awareness that difficulties with meditation experiences are not unusual and are even to be expected. They may manifest in a variety of ways, and there are different emphases in the way that these experiences are framed (for example, as a sign of negative karma, or terror about the dissolution of the self), but there is a set of symptoms that are understood as being caused by meditation practice, rather than being attributable to other organic causes.

Lindahl et al. (2017) focused on subjective self-report of experienced meditators of their own challenging experiences with meditation and their subjective self-report of the influencing factors. They developed a taxonomy of 59 challenging experiences associated with meditation and organized them into seven domains—cognitive, perceptual, affective,

somatic, conative, and social. They found that all the meditators reported challenging experiences across all of these domains. These varied in severity from having minimal to strong impact, with some leading to impairment that led to hospitalization. The duration of the symptoms also varied from lasting less than a week to over 10 years. The research team identified four domains of influencing factors which affected the intensity, desirability, and duration of the challenging experiences: practitioner-related, practice-related, relationships, and health behaviors.

These influencing factors are of particular relevance for this commentary, as careful attention to these may help chart a course in how to reduce or mitigate adverse meditation experiences. I therefore use the four categories of influencing factors that Lindahl et al. identified for highlighting some of their and other researchers' findings before proceeding to a discussion.

Influencing Factors for Adverse Meditation Experiences

Practitioner-Related

Practitioner-related influencing factors include temperament and medical, psychological, and trauma history. In Lindahl et al.'s study, some of these factors were associated with increased remedies. Many practitioners, though, made causal attributions between challenging meditation experiences and psychiatric or trauma history. The issue of the relationship between adverse meditation experiences and certain psychological difficulties has been explored in other studies. For example, the relationship between psychosis and meditation was discussed by Walsh and Roche (1979), who focused on three case studies where people with a history of schizophrenia experienced psychotic episodes apparently precipitated by intensive practice of transcendental meditation. Chan-Ob and Boonyanaruthee (1999) described three other cases of acute psychotic episodes experienced by practitioners on intensive Buddhist meditation retreats. In all the cases, there was insufficient evidence from the case studies to determine whether the meditation practice itself or in conjunction with pre-existing issues was the cause of the psychosis.

A similar argument was made by Sethi and Bhargava (2003) who, having considered some case studies, concluded that it was unclear whether meditation itself (as opposed to other contributing stressors, such as sleep deprivation) caused distress. Shonin et al. (2014a, b) found that limitations in available studies, and the presence of other causal factors, meant that there was not sufficient evidence to suggest that meditation can cause psychosis, and that in fact, there was some indications that certain forms of mindfulness meditation can be effective as a treatment for psychosis (see also

Chadwick et al. 2005; Dyga and Stupak 2015; Khoury et al. 2013).

A similarly inconclusive picture seems to emerge for other mental health-related difficulties. In their literature review about adverse reactions to mindfulness meditation, Lustyk et al. (2009) found various reports of mood and anxiety disorders associated with meditation. However, they also noted that a body of research suggests that mindfulness meditation can have therapeutic benefit for these mental illnesses. Generally, though, they argued that caution is warranted until further research about its risks and benefits is available:

For it remains of utmost importance that scholars protect research participants, especially those who belong to high-risk/special populations, by appropriately assessing risk and determining contraindication status until such time as empirical evidence proves the safe inclusion of all persons in general MM [mindfulness meditation] research. (p. 29)

Lindahl et al. (2017) found that one of the factors influencing whether a challenging meditation experience was perceived as aversive or pleasant was the frames of reference of the meditator:

Worldviews and explanatory frameworks were also influencing factors in that certain interpretations of the meaning of meditation-related difficulties could lead to further difficulties or the alleviation of certain dimensions of difficulties. Practitioners who reported holding or being offered multiple, conflicting worldviews were particularly likely to report on the influential—and often confusing—role of interpretive frameworks. (p. 23)

I have highlighted this finding here because it becomes very pertinent to the later discussion about the significance of different foundational conceptual frameworks in dealing with unusual meditation experiences. This is particularly important in terms of contemporary Western mindfulness, which, with its Buddhist roots and secular application, often exists in a borderland between the religious and the secular, creating potential tensions between these broad frameworks for making meaning. This is a point to which we shall return in the discussion.

Practice-Related

Of course, not all meditation practices are the same; there is considerable diversity of methods both within and across traditions. Lindahl et al.'s (2017) study and other research on adverse experiences identified the *type* of practice, the *stage* of practice, and the *response* to non-ordinary states of

consciousness (NSCs) as having an influence on the challenging meditation experiences.

Type of Practice

The two types of meditation most commonly practiced by the subjects in Lindahl et al.'s (2017) study were concentration, or focused attention (FA) meditation, and open monitoring (OM) or insight meditation. These two types were most frequently being practiced at onset of challenging meditation experiences and both types were equally associated with meditators' challenging experiences.

Focused attention meditation (FA) involves constantly returning the attention and focus on a particular sensation (such as the sensation of the breath in the nostrils) and redirecting one's concentration to this object when one becomes distracted. Open monitoring (OM) meditation involves observing the content of one's moment-to-moment experience in a non-reactive manner (Lutz et al. 2008). Although in Lindahl et al.'s (2017) study, these practices were undertaken in the context of Buddhist traditions, it was noted that both kinds of meditation (FA and OM) are "implicated in secular interventions that draw on Buddhist practices, such as mindfulness-based stress reduction." (p. 163). In other words, both open monitoring and focused attention meditation carried comparable risk for adverse meditation experiences.

Stage of Practice

The *stage* of meditation is significant in predicting the likelihood of distress. Epstein and Lieff (1981) identified two phases of meditation practice where difficulties seemed more likely to be encountered—at the preliminary stage of practice—when the meditator is learning how to focus the attention, and then much later, when attentional balance and steady concentration has been achieved and where the insights attained may be disorientating and distressing.

In terms of the preliminary practice, a practitioner first starting with focused attention practice will inevitably be faced with various mental and physical distractions and discomforts. Epstein and Lieff (1981) noted that practitioners may develop an aversive (as opposed to an accepting and compassionate response) to these distractions and become hyper-aroused, exhausted with excessive effort, and/or over-identified with the contents of the distracting thoughts and feelings. Once the mind has become very focused (*samadhi*, or access concentration) and moves into the phase of open monitoring meditation, different potentially troubling mental and physical phenomena may arise. Epstein and Lieff divided "meditative complications" into two categories: "one involving attachment to unusual, tranquil states of luminous clarity and one involving the process of disidentification from traditional ego structures" (p. 144).

Epstein and Lieff's findings were supported by Vanderkooi's (1997) study of Buddhist meditation theories:

As *samadhi* is achieved, "pseudo-nirvana" experiences of rapture, tranquility, and bliss can be accompanied by frightening images, uncomfortable body sensations such as itching, heat, and stiffness, and gastrointestinal problems of nausea, vomiting, and diarrhea. Then, sadness, irritability, extreme fear, and a deep sense of the insipid nature of life may manifest as one becomes more and more aware of the arising and passing away of phenomena. A desire for deliverance can emerge, and one may wish to discontinue practice. For example, the body may itch as though being bitten by ants. Later, when deciding to practice to completion, one may feel odd sensations such as being slashed by a knife. Finally, as equanimity is achieved and mindfulness and concentration become balanced and natural, practice becomes smooth and one may be able to meditate for hours. (Vanderkooi 1997, p. 32–33)

Vanderkooi (1997) interviewed Buddhist teachers in Theravadin, Zen, and Tibetan traditions about their experiences of meditative distress among their students and their recommended courses of action to address this distress. Teachers in each tradition found that these non-ordinary states of consciousness (NSCs) occurring in the earlier stages of practice tended to include "disturbing emotions and fantasies, perceptual aberrations and hallucinations, memories, and proprioceptive sensations and movements" (p. 40).

In line with Epstein and Lieff's two different categories of "meditative complications" above, some teachers noticed how NSCs had a different character in more advanced stages of meditation compared to the more preparatory phases. For example, a Zen teacher noticed that in the "pre-awakening phase," when students had attained access concentration and were in the open monitoring meditation, experiences tended to be "either very alluring, often involving religious symbols and blissful feelings, or very frightening and evocative of doubt" (Epstein and Lieff 1981, p. 40).

Two Tibetan teachers noted that NSCs at this more advanced phase of Tantric practice, meditators sometimes have visions of *vidams* or "deified aspects of mind." Meditation teachers in the study reported that psychosis is more likely to occur at the initial stages of meditation practice, because practitioners may not yet have developed the skills to use meditation to stabilize the mind to counteract the destabilizing effects of the NSCs. Psychosis was much less likely in the advanced stages of practice, because experienced meditation practitioners have developed the skills of equanimity and being able to let go; that is, they do not identify with NSCs.

The consensus among meditation teachers in the study was that "excessive effort and striving" in meditation practice

creates difficulties with NSCs and that contributing non-meditation factors were imbalances caused by stress, lack of sleep, and poor diet.

These points support Lindahl et al.'s (2017) findings that challenging meditation experiences can arise at various stages of meditation practice. The study also found that the amount of meditation practice prior to onset of the challenging meditation experience ranged from 1 day to 25 years, and for 72% of the practitioners, the challenging experiences occurred during or directly after a meditation retreat. This suggests not only that they can occur even in beginners, but also that intensity and duration of practice have influencing effects.

Response to Practice

Some studies suggested that the way a practitioner relates to an NSC (non-ordinary state of consciousness) or meditation challenge can exacerbate or ameliorate the distress associated with it. For example, meditation teachers in Vanderkooi's (1997) study reported that people prone to psychosis tended to respond to NSCs in ways that indicated a greater likelihood of a psychotic break. These responses included obsessions with NSCs, experiencing NSCs that are "negative, fearful and bizarre" in nature, fears of going insane, and emotionally disconnected states. The more that practitioners identified with these states, the more likely they were to have psychological distress, leading in extreme cases to psychosis: "the teachers defined psychosis as a problem of overidentifying with NSC and being unable to disidentify and let go" (p. 40).

Birchwood and Chadwick (1997) found that psychotic patients respond to experiences of voices and paranoid delusions with confrontation and rumination and that both of these were characterized by attitudes of resistance. Patients who learned mindful and non-judgmental observation of these experiences tended not to identify with these experiences, or follow them (rumination), which had the effect of reducing the distress associated with fighting experiences.

A study by Kerr et al. (2011) of participants of an MBSR course found that as the course progressed, each participant used less judgmental and reactive language to describe their experiences with mindfulness practice, even when those experiences were distressing. This process was associated with improved affect. The authors concluded that "Progress in MBSR may rely less on the valence of participants' experiences and more on the way participants describe and relate to their own inner experience" (Kerr et al. 2011, p. 80). Here, then, a common thread for coping with unpleasant or frightening NSCs is changing to a more open-monitoring kind of practice which incorporates an attitude of acceptance and disidentification towards these experience.

In VanderKooi's (1997) study, there was some variation between the different Buddhist traditions about how to manage NSCs, although many indicated a different type of

meditation as appropriate. For Theravada teachers, this included balancing excessive concentration practices with mindfulness practices including awareness of body sensations, *metta* (loving kindness) meditation, and physical activity. Zen teachers suggested moving students away from concentrative practices, such as *koan* practice, and more towards breath awareness or *shikantaza* practice. Tibetan teachers recommended investigating health imbalances, which might be contributing to the difficulties, and also reducing the length of the meditation practice and increasing it only slowly.

Even though the particular expression of these practices is different, there are some commonalities. Each suggested awareness of body sensations or the engagement in physical activities as a way of counteracting excessive concentration. They all recommended balancing concentration with mindfulness and broader awareness (as opposed to very focused concentration), where students "lighten up" and watch the contents of the mind without effort. This coincides with the findings of Lindahl et al.'s (2017) study that changing a practice type or complementing it with another type was offered as a remedy for certain meditation difficulties. Lindahl et al.'s study also found that experts in particular saw some difficulties as a necessary part of a certain stage of the practice and that subsequent stages of practice were assumed to resolve these difficulties (p. 23).

"Meditative remedies" were not always suggested, though. The Buddhist meditation teachers in Vanderkooi's (1997) study did not limit themselves to tools exclusively from Buddhist traditions (e.g., changing the form of meditation) to address difficulties their students were experiencing. Many consulted with Western psychologists about psychological problems in their students. They also reported pushing students less hard than they had earlier in their teaching careers, noting that "in general, pushing students to 'break through' does not facilitate integration of enlightenment experience and can damage students who are psychologically fragile" (p. 40). For students with a history or current presentation of mental illness, they often recommended Western medication and therapy. In other words, remedies for adverse meditation experiences were not always meditative in nature.

Health Behavior-Related

Lindahl et al.'s (2017) study found that practitioners saw imbalances in certain health behaviors as affecting their meditation experiences. These influencing factors could again be positive or negative: "lack of sleep, inadequate diet, and lack of exercise tended to be associated with (or preceded) destabilizing experiences, and could be corrected as remedies by increasing sleep amount, making dietary changes, or getting exercise, as well as by engaging in other activities described as grounding, calming, or embodying" (p. 24).

All the meditation teachers interviewed in Vanderkooi's (1997) study agreed that sometimes non-meditation factors, such as lack of sleep, poor diet, or stress contributed to problematic experiences with meditation. All the teachers found that excessive effort and striving were associated with difficult NSCs. In terms of tradition-specific observations, some Theravadin teachers found that problems tended to arise when concentration practice was not balanced with mindfulness. Tibetan teachers found that "improper use of certain advanced meditation practices" (p. 40) led to imbalances of energy flow within the body, resulting in disturbing experiences. Zen teachers noticed that difficult NSCs often arise at the attainment of *samadhi* and also found that incorrect breathing and poor posture could contribute to these difficulties. It is apparent, then, that there may be a synergistic relationship between wider health-related factors and meditative practice in terms of risks for adverse experiences.

Relationship-Related

Some of the relationship-related factors that subjects in Lindahl et al.'s (2017) study identified were relationships within meditation communities (particularly with teachers), relationships beyond the meditation community, the surroundings and environment of the meditation practice, and the relationship with the sociocultural context. In each of these categories, relationships could be either a risk or a remedy for adverse meditation experiences. In terms of teachers and meditation communities, unsympathetic or unsupportive relationships were risk factors, and helpful and understanding ones were remedies. Early life family relationships were influencing factors on psychiatric or trauma history. In terms of practice surroundings and environments, the social isolation and silence of a retreat context were common risk factors, as was transition from retreat contexts to challenging and destabilizing environments (Lindahl et al. 2017, p. 24).

Of particular relevance to this article is the fact that the wider sociocultural context the practitioner inhabited had an influencing factor on adverse meditation experiences:

When there was compatibility and fit, sociocultural contexts could be part of a remedy. However, experts and practitioners alike also suggested that certain sociocultural contexts could be risk factors, particularly when there was a mismatch between a practitioner's and a teacher's cultural background and social customs. Another interpretation offered was that mismatches between practitioners' meditation experiences and worldviews and values of their sociocultural contexts could create a tension that would lead to or compounded difficulties. (Lindahl et al. 2017, p. 24)

Discussion

To sum up, this brief survey of research about adverse meditation experiences suggests great variability dependent on contextual factors. Lindahl et al.'s (2017) study found—both in terms of phenomenology of meditative experiences and influencing factors—that the degree to which an experience or factor was appraised as helpful or harmful was "highly variable and case specific" (p. 24). In their discussion of the results, the authors emphasized the "central role of appraisal" in the interpretation of meditation experiences and that "there are multiple, and sometimes conflicting, interpretative frameworks at play for Western Buddhist meditators" (p. 5).

The values that affect these appraisal frameworks are influenced not only by the way authorities within a particular Buddhist tradition appraise a meditative experience, but also by other prior conceptual frameworks from media, family, communities, and philosophical and theoretical perspectives.

Within Buddhist traditions there may be variation in models for coping with meditation experiences: "what is categorized as 'progress' versus 'pathology' may differ across traditions, lineages, or even teachers" (Lindahl et al. 2017, p. 25). Even then, access to such models may only be available to people working closely with a teacher. Lindahl et al.'s (2017) study focused only on Buddhist meditators, but the authors noted that Buddhist models for coping "may be inadequate for Western meditators who seek meditation for therapeutic reasons and who are embedded in a scientifically-oriented culture, where biomedical and psychological frameworks have a pervasive influence" (Lindahl et al. 2017, p. 25).

Mindfulness meditation is an area where different narratives about meditation, spirituality, and mental health encounter each other. These could be narratives from within strands of Buddhist traditions or from Buddhist-informed versus secular psychological approaches. These narratives can converge or diverge.

For example, one area where context may lead to a divergence and conflict between narratives is during the earlier stages of meditation practice, when the meditator might start to have unsettling experiences. In Buddhist meditation contexts, the tendency may be to focus on the *process* of the meditation experiences (i.e., seeing them as a passing phase not to be identified with), rather than on their content (Collins 2015; Dyga and Stupak 2015; Vanderkooi 1997).

However, if these meditation techniques are used outside the context of Buddhist traditional teachings, this could be problematic, because the context and support for dealing with them may not be present, and/or the participant may be coming from a different frame of reference. For example, from a Western psychoanalytical perspective, meditation is therapeutic in part because it allows the practitioner to enter into adaptive (as opposed to pathological) regressive states where childhood traumas are "remastered" (Shafii 1973). In other words,

here there may be more focus on the content of the experiences.

This divergence between traditional Buddhist and Western psychological approaches can manifest as problematic in both contexts. From the Western psychoanalytical perspective, it is problematic if the practitioner mistakes some of the feelings and fantasies that emerge during meditation practice as signs of meditative or spiritual transformation, when in fact, they are part of a developmental process of ego regression.

These kinds of problems cannot be resolved when instructors direct students to focus solely on the process, instead of the content of the experience, and, as opposed to traditional forms of meditation rooted in the spiritual tradition, a framework in which such material could be worked through does not exist. According to Epstein & Lieff, psychosis can manifest among meditators with poorly developed ego, who use primitive defence mechanisms of denial, delusional projection and distortion of regressive forces. (Dyga and Stupak 2015, p. 53)

This important point reflects the arguments of Lindahl et al.'s (2017) study: adverse meditation experiences become problematic *when there is no framework for working through difficult material* or when the frameworks being offered to the meditator are so unfamiliar to them that they are not helpful in making meaning. This, of course, could implicate “secular” mindfulness programs, when the meditation is not framed within the meaning-making contexts of Buddhist traditions. In this case, an alternative context for support and “working through” the material should be considered, such as psychotherapy. On the other hand, divergence could work in the opposite direction; framing meditation experience in terms of psychological reductionism or pathology, rather than as part of a process of spiritual growth, may inhibit or block the possibility of insight:

Epstein & Lieff [24], speaking about meditation viewed more as a spiritual practice, warn about psychological reductionism, which leads to labelling as regressive, if not even psychotic, states and experiences that could be otherwise conceptualized as mystic, or, to use a language not affiliated with spirituality, states that involve a transformation of the ego. (Dyga and Stupak 2015, p. 53)

A similar point is made by Yorston (2001) in regards to how traditional psychiatry might appraise a spiritual process:

Grof and Grof (1989) have argued however that traditional psychiatric thinking fails to recognize the difference between mystical and psychotic experiences, tending to underestimate the potential for a healing

and positive transformation of what the authors term a transpersonal crisis. (Yorston 2001, p. 212)

In transpersonal psychology, a distinction is made between “spiritual emergence” and “spiritual emergency” (Grof and Grof 1989). The term spiritual emergence is evocative of a kind of metamorphosis in which an individual emerges from existential and psychological difficulties encountered on their spiritual journey to attain a higher level of spiritual growth and maturity. A spiritual emergency, on the other hand, describes a condition where the distress is overwhelming and one becomes “stuck” in the state of discomfort, disorientation, and decompensation; this in turn may lead to a psychiatric or psychological emergency. As Lindahl et al.'s (2017) study indicates, multiple contextual factors may influence whether a challenging meditation experience becomes emergence or emergency. The authors emphasized this point about the significance of appraisal in relation to secular versus religious domains:

Many of the experiences reported by practitioners in our study resemble to varying degrees phenomena discussed in the vast literature on schizophrenia, schizotypy, psychosis, as well as non-psychopathological forms of anomalous experience. Without sufficiently attending to the role of appraisal processes at both individual and interpersonal levels, scholars may fundamentally misconstrue differential diagnosis as being about identifying inherent differences between religious experiences and mental illnesses, rather than seeing them as potentially more ambiguous categories or closely related phenomena that may well be grounded in common cognitive, perceptual, and behavioral mechanisms. (Lindahl et al. 2017, p. 26)

There may also be fundamental divergence in terms of the goals of meditation. For example, while both Western science and Buddhism might be said to be concerned with addressing the problem of suffering, they do so in very different ways:

Buddhism has historically sought a solution to suffering in inner transformation and a corresponding commitment to the highest ethical ideals, whereas science has sought a solution through knowledge that would ease the human estate through manipulation of the material world. (Harrington, 2002, p. 19)

Both Buddhist and Western psychology might be said to value the attainment of happiness, but how happiness is understood by each broad tradition is very different (Kirmayer 2015). As Ekman et al. (2005) pointed out, Western psychology tends to equate happiness with feelings of positive emotions and subjective well-being. In Buddhist traditions, genuine happiness

(*sukha*) is associated with an enduring trait that arises from training the mind:

Rather than a fleeting emotion or mood aroused by sensory and conceptual stimuli, *sukha* is an enduring trait that arises from a mind in a state of equilibrium and entails a conceptually unstructured and unfiltered awareness of the true nature of reality. (Ekman et al. 2005, p. 60, from Cutz et al. 2015, p. 342)

Lindahl et al. (2017) suggested that some of the adverse experiences in meditation may be attributed to “a lack of fit between practitioner goals and expectations and the normative frameworks of self-transformation found within the tradition”, and to a tension about which narratives are prioritized: “Thus, Western Buddhist practitioners not only have to navigate multiple interpretative frameworks, but also different opinions about which frameworks have authority” (p. 25).

Some of these differences may account for the variation in receptivity and engagement between Western forms of Buddhism and Western psychology. As Gleig (2012) discussed, some Western Buddhist traditions have been skeptical of engaging with Western psychology, fearing the reduction of Buddhist thought into Western paradigms. Other Buddhist groups have engaged in a more dialogic (as opposed to reductive) relationship with Western psychology. This tension between dialog and reductionism is seen in other areas where Buddhist and Western traditions meet.

A good example of this is the current debate about the growth of mindfulness in secular contexts in the West and whether this amounts to an enabling of neoliberal agenda of individual prosperity (the “McMindfulness” critique) or an inappropriate infiltration of “spiritual” or “religious” values into the secular arena (the “Stealth Buddhism” critique) or a helpful and mutually beneficial dialog between different narratives (Monteiro et al. 2015).

In the remainder of this paper, a case is made for a dialogic, pluralistic engagement between these narratives (or families of narratives, as neither Western science nor Buddhism are monolithic) as being indicated for addressing adverse meditation experiences.

A Middle Path of Mutually Enriching Dialog

A model of a middle path, dialogic approach was provided by Grabovac (2015), a psychiatrist who argues that teachers of MBIs should develop a better understanding of Buddhist psychology, particularly the stages of insight as laid out by Theravada Buddhism (although she does mention similar maps from other Buddhist traditions, she focuses on the stages of insight for her argument). The stages of insight describe a “predictable developmental sequence” mapping a meditator’s progress as she develops greater concentration and

mindfulness. They describe signs and symptoms of increasing development in these respects, including symptoms of distress. Grabovac gave three reasons why it is important for MBI clinicians to become familiar with the stages of insight.

Firstly, even novice meditators engaging in an 8-week MBI sometimes progress quickly through the initial stages of insight: “experiencing these stages may not be exclusive to advanced students of vipassana” (Grabovac 2015, p. 2). If MBI clinicians are familiar with how the stages of insight present, they will be better equipped to help students understand their experiences.

Secondly, being able to recognize the stages of insight allows for instructions that are tailored to the individual student’s needs:

MBI clinicians who are able to recognize the stages of insight in the descriptions of meditation experiences given by group participants can adjust the practice instructions accordingly to increase the effectiveness of the participant’s practice, and therefore possibly of the MBI itself. (Grabovac 2015, p. 2)

Thirdly, as we have seen, the stages of insight explain how certain stages may be accompanied by distressing experiences. This knowledge would help prepare MBI clinicians (and their students) for coping with these experiences and challenge assumptions that MBIs are always benign:

There is a common view amongst MBI clinicians and group participants that mindfulness based interventions are solely beneficial or benign; however, within the Theravada Buddhist tradition, it is understood that meditators progressing through the stages of insight may undergo experiences that are extremely psychologically challenging, and that these may become clinically significant as a result of associated functional impairment (for examples, see Sangharakshita 2004; Sharf 1995). (Grabovac 2015, p. 2)

This third point has important ethical implications. Grabovac (2015) noted that once an MBI has been completed, students are encouraged to “keep practicing on their own.” It is possible that while they do this, they experience the later stages of insight, and the attendant potentially distressing experiences, on their own. This deviates from at least two ethical standards of care and best practices of modern psychology and medicine. Firstly, it violates best practice of ongoing monitoring of a therapeutic intervention: “Given that MBIs are being “prescribed” and delivered in medical treatment settings, the exhortation to continue active treatment beyond any medical follow-up in the context of the possibility of significant side effects, albeit rare, is a cause for concern” (p. 10). Secondly, it violates the practice of informed consent about the “inherent

risks and potential side effects of the treatment, including, and especially, the disclosure of rare and uncommon side effects that have potentially significant sequelae” (p. 10).

Far from being a putative unethical introduction of stealth Buddhism into a secular context, awareness of the stages of insight as described by (in this case) Theravada Buddhist traditions provides information and support to MBI clinicians and their students. Accusations of stealth Buddhism assume that the stages of insight are a doctrine or ideology. It is more fitting, helpful, and conducive to dialog and to frame them instead as a description of a psychological process accompanying meditative activities, whether or not they are undertaken in the context of a “Buddhist” training or retreat. As Amaro (2015) stated it in his call for a holistic mindfulness:

The nondogmatic approach of Buddhism can be seen to fall in the fertile littoral zone between the doctrinaire religiosity of one camp and the staunch scientific materialism of the other. The more that these pragmatic principles of traditional Buddhism are appreciated, the more that those delivering MBIs might feel comfortable in consciously drawing upon them and recommending them as resources to their clients. (Amaro 2015, p. 71)

To limit the guidance and support that comes from the “map” of the stages of insight only to meditators practicing in Buddhist contexts may be unethical, particularly when the process of meditative insight occurs whether one is practicing in a Buddhist framework or not. Vipassana teachers are very familiar with guiding students through the stages of insight have developed modifications in their meditation instruction tailored specifically to the “symptoms” and the stage of insight that a student is encountering. Furthermore, since many are psychologically or psychotherapeutically trained, they are in fact already using Western concepts to adapt Buddhist approaches. Grabovac (2015) describes some of these modifications and calls for MBI clinicians to be trained in the stages of insight so that they, too, can tailor their instructions to the needs of their students.

This is an area rich with possibilities for collaborative research and dialog between science and Buddhism. For example, empirical research could be conducted into the extent to which the stages of insight provide a helpful heuristic for mapping and understanding the experience of meditators and the risks and benefits of each stage.

Recommendations

Various recommendations emerge from the sources and perspectives that we have explored in this article. Our review of the literature suggests that adverse meditation experiences may be more likely depending on the *stage* or *phase* of a

particular practice, the *type* of meditation, and the *response* or *contextualizing* of these difficulties.

In terms of stage of practice, we have seen how there are certain points in the meditation process (i.e., early in the “focused attention” or *samatha* and later during the open awareness phase when access concentration has been attained) where distressing experiences are more likely to occur. Depending on the stage, different approaches for coping with this distress are indicated. It may be that in the earlier phases, a reduction in the intensity of meditation and the introduction of psychotherapeutic support to help the individual process states of ego-regression are most appropriate.

Distress at the later phase may correspond to the unsettling experiences associated with deepening insights and be more appropriately managed with meditation on the arising and falling of phenomena. Therefore, it is important that a mediation teacher understands the “topography” of the meditation experience and where the student is during the process. Detailed maps of this landscape are provided by Buddhist traditions. To the extent that these can help deepen a teacher or clinician’s ability to guide their students or clients, awareness of these maps is indicated. For these maps to be useful in facilitating dialog, they might need to be examined through the lens of empirically-oriented scientific inquiries. As Grabovac (2015) argues, this knowledge should be grounded in *experience*, rather than being merely conceptual knowledge:

Because there is currently no validated, research based set of diagnostic criteria that can be used to confidently ascribe a meditator’s experiences to a particular stage of insight, personal experience of the stages in the clinician’s own practice, at least to the stage of equanimity, as well as experience working with numerous students as they navigate through the stages, is required to attain competency in this area. MBI clinicians with a solely conceptual, rather than experiential, understanding of the stages of insight should consider referring participants who are possibly progressing through the stages to more experienced clinicians (i.e. with personal experience of all of the stages of insight) for evaluation and practice recommendations. (p. 10)

Another significant point relating to the stage of practice is that the process of meditative training does not necessarily end when a formal MBI training, or a Buddhist retreat finishes. Individuals who continue to practice on their own may end up progressing through different phases but without support may encounter difficulties in resolving their troubling experiences. An important line of future inquiry could be developing and testing post-intervention or retreat support mechanisms and processes.

Related to this point is the significance of the type of meditation. Certain meditation practices may be contraindicated

depending on the mental health history of the meditator, and/or on the particular stage they are at in their meditative practice. Shonin et al. (2014a, b) recommend various adaptations to MBIs to mitigate the risk of meditation-induced psychosis or other distress. Although primarily addressing the issue of meditation and psychosis, many of these recommendations are generalizable to meditation in other contexts; more studies like Shonin et al.'s into these different kinds of context may help to reduce the incidence of meditation distress.

Another often-neglected aspect to consider is the extent to which personality type may effect appropriateness or efficacy of different types of meditation. Buddhist traditions provide taxonomies of variations in personality types and meditation practices indicated for each type (Buddhaghosa and Ñāṇamoli 1997; Law 1969). Contemporary research in secular mindfulness is just beginning to address this question about the “fit” between personality and types of meditation, but there is currently a paucity of research about it (Nyklíček and Irmischer 2017). This is another area in which dialog between traditional Buddhist and contemporary psychological approaches could be very fruitful.

It is important to recognize that any person may have multiple narratives for making meaning and sense out of their experiences, suggesting that a broad approach incorporating a variety of modalities is the most helpful. Research focusing on the synergies or tensions between psychopharmacology, psychotherapy and meditation practice is called for. Grabovac (2015) reports that her clinical experience suggests that meditation be supported with other therapeutic modalities:

Based on the author's clinical experience, and in the absence of any published data, the use of all available and clinically indicated treatment modalities, including pharmacotherapy, in the management of psychiatric syndromes arising during progress along the stages of insight is indicated at this time. (p. 11)

Being open to other narratives and modalities helps to moderate the tendency to become ideologically fixed on the primacy of one particular narrative. Reducing experiences to one narrative limits the availability to potentially helpful resources offered by different narratives. Deepening dialog between secular and traditional Buddhist approaches does not mean that one narrative must be subsumed by another; syntheses and new understandings may emerge (Sun 2014; Vörös 2016).

Each person has their own motivations and particular context that has brought them to meditation and their own narratives for making sense of their place in the world. The term “spirituality” can be a short hand for these ways of making meaning. Initiatives such as the George Washington Institute for Spirituality and Health (GWISH) promote a dialogic

approach between spirituality and health care, with the term spirituality broadly understood:

Spirituality is recognized as a factor that contributes to health in many persons. The concept of spirituality is found in all cultures and societies. It is expressed in an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another. (Puchalski, n.d.)

A skillful meditation teacher or clinician will listen sensitively to their student/patient's narratives for making meaning. It is not required that they share those understandings nor is it necessary to try to change or influence the student/patient's perspective in order to teach MBIs or meditation skills. However, being sensitive to the individual's perspective provides a context of compassion and understanding that is conducive to healing:

Spirituality is the basis for the deep, caring connections physicians and healthcare professionals form with their patients. While cure may result from technical and disease oriented care, healing occurs within the context of the caring connection patients form with their physicians and healthcare professionals. This is why spirituality is essential to all of medicine and healthcare. (Puchalski, n.d.)

As meditation, whether within the context of Buddhist or secular mindfulness traditions, grows in popularity in the West, the incidence of adverse experiences is likely to increase. A prerequisite for informed and skillful dialog is increased awareness and understanding. In his book *Cosmopolitanism*, Kwame Anthony Appiah argues that “the most fundamental level of disagreement occurs when one party to a discussion invokes a concept that the other simply doesn't have. This is the kind of disagreement where the struggle is not to agree but to understand” (Appiah 2010, p. 47). I would like to join others (such as Gleig 2012; Grabovac 2015; Kirmayer 2015; Lindahl et al. 2017; Monteiro et al. 2015; Van Gordon et al. 2016) in calling for more research and inquiry into these questions in a spirit that is dialogic, rather than reductionist.

A dialogic approach is characterized by curiosity and the willingness to learn from alternative ways of acting, thinking, feeling, and understanding (Appiah 2010) and is open to innovation and adaptation. A reductionist approach tries to reduce these alternative narratives into the terms of one's own discourse and closes down conversation. Dismissing the use of Buddhist resources because they are religious or spiritual is to be hamstrung by inappropriately applied conceptions of

Buddhist/religious versus secular (Compson 2017). These conceptions falsely imply territorial and therefore ethical boundaries between what can actually be mutually supportive traditions.

The unprecedented opportunities for cross-cultural communication provide the conditions for both greater intolerance and greater mutual understanding. Organizations like GWISH and the Mind and Life Institute are dedicated to fostering dialog between spiritual and scientific communities and remove “institutional, disciplinary, methodological, and geographic” silos (Bauer-Wu 2016). Through conferences, trainings, and promotion of research, they convene communities and create opportunities for shared inquiry and discussion. As such, they serve as models for the kind of dialog and exploration I am calling for here. The forum provided by this journal also provides an excellent opportunity for interdisciplinary dialog about adverse meditation experiences, a dialog that could considerably alleviate present and future suffering.

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Compliance with Ethical Standards

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